San Mateo County Behavioral Health and Recovery Services

Fiscal Year (FY) 19/20 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

Requirement

System Review Item 1 *(Access and Information Requirements)*

DHCS Finding

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has written materials that are critical to obtaining services available in the prevalent non-English languages in the county. Specifically, denial and termination notices.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 11, and Federal Code of Regulations, title 42, section 438, subdivision 10(d)(3). The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

1. The MHP has created the required documentation available in our threshold languages, English, Spanish, Cantonese, Mandarin, and Tagalog. These documents are available for use as fillable form letters by staff. These documents and instruction guide are found on our Consumer Problem Resolution webpage and are available to all staff and contractors at https://www.smchealth.org/bhrs-policies/consumer-problem-resolution-noa-19-01

Proposed Evidence/Documentation of Correction

1. Denial and Termination Notices in Threshold languages. (zip folders)

Attach_A_NOABD Denial_Threshold Languages.zip

Attach_B_NOABD Termination_Threshold Languages.zip

Implementation Timeline: Completed

Requirement

System Review Item 2 *(Access and Information Requirements)*

DHCS Finding

DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). Each MHP must provide a statewide, toll-free telephone number 24 hours a day, seven days per week that will provide information to beneficiaries about how to access SMHS and how to use the beneficiary problem resolution and fair hearing processes.

Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). The MHP must complete a CAP addressing this finding of partial compliance.

Corrective Action Description

1. Access Call Center Manger will review and edit call Scripts to include required information on Accessing SMHS services and the beneficiary problem resolution system.

2. Call Center Manager will review revised call scripts and procedures on required information to beneficiaries to all BHRS Access Call Center staff.

Proposed Evidence/Documentation of Correction

1. Plan of Correction to Call Center Manager.

Attach_C_DHCS Audit Finding FY2019_2020_POC_Access Call Center.pdf

2. Call Center Manager to provide Meeting agenda and sign-in sheets for training provided to Access Call Center Staff.

Implementation Timeline:

1. Plan of Correction Letter sent 12/8/2020

2. Evidence of action due to QM by 1/17/2021

Requirement

System Review Item 3 *(Access and Information Requirements)*

DHCS Finding

The MHP submitted evidence to demonstrate compliance with this requirement, three (3) of five (5) required DHCS test calls were not logged on the MHP's written log of initial request.

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f). The MHP must complete a CAP addressing this finding of partial compliance.

Corrective Action Description

1. Call Center Manager will review call logging procedures and requirements with BHRS Access Call Center staff. Review will include call log required beneficiary information for requests for SMHS.

Proposed Evidence/Documentation of Correction

1. Plan of Correction to Call Center Manager.

Attach_C_DHCS Audit Finding FY2019_2020_POC_Access Call Center.pdf

2. Call Center Manager to provide Meeting agenda and sign-in sheets for training provided to Access Call Center Staff

Implementation Timeline:

1. Plan of Correction Letter sent 12/8/2020

2. Evidence of action due to QM by 1/17/2021

Requirement

System Review Item 4 *(Beneficiary Rights and protections)*

DHCS Finding

The MHP must acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing meeting above listed standards.

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

Corrective Action Description

1. OCFA will review the BHRS Policy 19-01 Consumer Problem Resolution and Notice of Adverse Benefits Determination Resolution System with the OCFA team

2. Specifically review requirements to send written acknowledgement to beneficiaries within five (5) calendar days of receipt of grievance or appeal.

3. OCFA will create formal standing agenda items to review Notification and Documentation timelines and due dates to ensure that timelines followed.

Proposed Evidence/Documentation of Correction

1. Plan of Correction Letter sent to OCFA program supervisor and reviewed in Grievance and Appeals Team Meeting.

Attach_D_DHCS Audit Finding FY2019_2020_POC_OCF.pdf

Attach_G_GAT Minutes 12112020

2. Sample OCFA Staff Meeting Agenda incorporating formal standing agenda items to review Notification and Documentation timelines and due dates to ensure that timeline requirements are followed.

Implementation Timeline:

1. POC Letter Sent 12/8/2020

2. Evidence of Action due to QM by 1/17/2021

Requirement

System Review Item 5 *(Beneficiary Rights and protections)*

DHCS Finding

MHP did not log grievances and appeals within one (1) working day of the date of receipt of the grievance, appeal, or expedited appeal. Specifically, five (5) of the 48 grievances reviewed were not logged within one (1) working day of the date of receipt of the grievance.

DHCS deems the MHP partial compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must complete a CAP addressing this finding of partial compliance.

Corrective Action Description

1. OCFA will review the BHRS Policy 19-01 Consumer Problem Resolution and Notice of Adverse Benefits Determination Resolution System.

2. Specifically review requirement for logging grievances within one (1) business day of receipt of grievance.

Proposed Evidence/Documentation of Correction

1. Plan of Correction Letter sent to OCFA program supervisor and reviewed in Grievance and Appeals Team Meeting.

Attach_D_DHCS Audit Finding FY2019_2020_POC_OCF.pdf

Attach_G_GAT Minutes 12112020

2. Sample OCFA Staff Meeting Agenda incorporating formal standing agenda items to review Notification and Documentation timelines and due dates to ensure that timeline requirements are followed.

Implementation Timeline:

1. POC Letter Sent 12/8/2020

2. Evidence of Action due to QM by 1/17/2021

Requirement

System Review Item 6 *(Beneficiary Rights and protections)*

DHCS Finding

While the MHP submitted evidence to demonstrate compliance with this requirement, it was found that some of the grievances were not resolved within the 90 calendar days from the day the Contractor receives the grievance.

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

Corrective Action Description

1. OCFA Supervisor will review the BHRS Policy 19-01 Consumer Problem Resolution and Notice of Adverse Benefits Determination Resolution System with the OCFA team.

2. Specifically review: requirement for resolving grievances within 90 days.

3. The OCFA team will Incorporate due dates in their internal tracking within their team and with the larger Grievance and Appeals team meetings.

4. A Standing agenda item will be added to OCFA Team meeting agenda to review grievances that are unresolved at 60 Days. For those grievances they will make a priority plan to resolve them within the 90 day timeframe requirement.

Proposed Evidence/Documentation of Correction

1. Plan of Correction Letter sent to OCFA program supervisor and reviewed in Grievance and Appeals Team Meeting.

Attach_D_DHCS Audit Finding FY2019_2020_POC_OCF.pdf

Attach_G_GAT Minutes 12112020

2. Sample of OCFA internal tracking document showing incorporated due date section.

3. Sample Agenda incorporating priority review of Grievance items unresolved at 60 days.

Implementation Timeline:

1. POC Letter Sent 12/8/2020

2. Evidence of Action due to QM by 1/17/2021

Requirement

System Review Item 7 *(Program Integrity)*

DHCS Finding

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subd. 608(a)(5). The MHP must implements and maintains procedures designed to detect fraud, waste and abuse that include provisions to verify services reimbursed by Medicaid were received by the beneficiary.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subd. 608(a)(5). The MHP must complete a CAP addressing this finding of non-compliance

Corrective Action Description

1. BHRS Quality Management and Billing Department will develop a procedure for client service verification.

2. BHRS will develop a report that compares claimed services against the Avatar Scheduler for appointments that have not been checked in on the Avatar Scheduler but have a service that was claimed.

3. A sample list of client services will be generated. These client will be contacted by BHRS to verify service was delivered.

4. Designated BHRS staff will contact the clients on the sample list and note their response in a log.

Proposed Evidence/Documentation of Correction

1. Documentation of Service Verification Procedure.

2. Sample report of claimed service with no checked in scheduler appointment.

3. Sample of completed contact and verification log.

4. Evidence of training selected BHRS staff on procedure.

Implementation Timeline:

1. Service Verification Procedure by March 31, 2021.

2. Evidence of Completion by 7/1/2021

Requirement

System Review Item 8 *(Program Integrity)*

DHCS Finding

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP promptly notifies DHCS if the MHP finds a party that is excluded during the database check as the MHP does not include this requirement in their policy and procedure and did not submit evidence of practice.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 608 and section 455, subdivision 436. The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

1. BHRS Quality Management updated Policy 19-08 Credentialing and Re-Credentialing Providers to include the requirement to notify DHCS immediately if a provider is found to be excluded from Medicare and Medi-Cal. (See page 10).

2. Policy 19-08 was presented at the BHRS QIC meeting on December 9, 2020 with specific update discussed.

Proposed Evidence/Documentation of Correction

Updated policy and QIC agenda discussing updated policy:

Attach_E_19-08 Credentialing_Re-Credentialing_sig on file_tech edit_11-5-2020.pdf (supersedes 04-01)

Attach_F_QIC_Agenda-12-09-20.pdf

Implementation Timeline: Completed

Requirement

System Review Item 9 *(Other Regulatory and Contractual Agreements)*

DHCS Finding

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submitted its annual cost reports timely. Specifically, the MHP sought an extension for FY 18/19 but did not meet extension deadline.

DHCS deems the MHP out of compliance with California Welfare and Institution Code, section 14705(c) and 14712(e). The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

1. BHRS Finance Department will provide evidence of standing agenda items emphasizing importance of timely delivery in team meetings and review of milestone workplan.

2. BHRS will develop a project schedule for completing tasks to streamline and automate Cost Report functions focusing on salary and benefit schedule, and operating expenses to specific programs.

3. BHRS will train employees on task currently handled by outside consultant.

4. Schedule interim check-in meetings and review log of milestones completed.

Proposed Evidence/Documentation of Correction

• Sample of Finance department agenda incorporating discussion for timely cost report delivery, discussion of project milestones completed.

• Project Schedule on automation upgrades for cost report production

Implementation Timeline:

1. Evidence is due to QM by 3/31/2021

Requirement

Survey Only Item 1 *(Authorization Requirements for Concurrent and Prior Authorization)*

DHCS Finding

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP complies with the communication requirement that a physician shall be available for consultation and for resolving disputed requests for authorization.

DHCS recommends, at a minimum, the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements, or to strengthen current processes in this area to ensure compliance in future reviews:

- Update your policies to reflect the above requirements

Corrective Action Description

1. The following policies were updated with the suggestions actions.

a. Policy 20-05 UM Program and Authorization of SMHS

b. Policy 20-06 UM of Inpatient Psychiatric Services

2. Policies were presented at Quality Management's QIC meeting on December 9, 2020 with an emphasis on suggestion changes.

Proposed Evidence/Documentation of Correction

Updated policy and QIC agenda discussing updated policy:

Attach_H _20-05_UM_Program SMHS_sig on file_Amended_11-5-2020.pdf

Attach_I_20-06_UM of Inpatient Psychiatric Services_sig on file_Amended_11-5-2020.pdf

Attach_F_QIC_Agenda-12-09-20.pdf

Implementation Timeline: Completed

Requirement

Survey Only Item 2 *(Authorization Requirements for Concurrent and Prior Authorization)*

DHCS Finding

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident and it is not spelled out In the policies and procedures provided by the MHP that the MHP reviews that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administration day status.

DHCS recommends, at a minimum, the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements, or to strengthen current processes in this area to ensure compliance in future reviews:

• Update your policies to reflect the above requirements.

Corrective Action Description

1. The following policies were updated with the suggestions actions.

a. Policy 20-05 UM Program and Authorization of SMHS

b. Policy 20-06 UM of Inpatient Psychiatric Services

2. Policies were presented at Quality Management's QIC meeting on December 9, 2020 with an emphasis on suggestion changes.

Proposed Evidence/Documentation of Correction

Updated policy and QIC agenda discussing updated policy:

Attach_H_20-05_UM_Program SMHS_sig on file_Amended_11-5-2020.pdf

Attach_I_20-06_UM of Inpatient Psychiatric Services_sig on file_Amended_11-5-2020.pdf

Attach_F_QIC_Agenda-12-09-20.pdf

Implementation Timeline: Completed

Chart Review

Requirement

MEDICAL NECESSITY

DHCS Finding

FINDING 1A-3b:

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

Specifically: Letter/appointment (1 note) rescheduled, immigration letter (1 note)

FINDING 1A-3b1:

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

Voicemail (1 note) and copying (1 note)

CORRECTIVE ACTION PLAN 1A-3b:

The MHP shall submit a CAP that describes how the MHP will ensure that all SMHS interventions are reasonably likely to correct or reduce the beneficiary's documented mental health condition, prevent the condition's deterioration, or help a beneficiary who is under age 21 to progress developmentally as individually appropriate.

CORRECTIVE ACTION PLAN 1A-3b1:

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

1) Each progress note is individualized, and describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning, as outlined in the client plan.

2) Services provided and claimed are not solely clerical.

3) 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).

Corrective Action Description

1. Providers/programs were notified of audit results and re-training occurred- BHRS informed program management and providers of billing errors related to medical necessity. Programs were required to meet and train staff.

2. Live Training -BHRS QM provided a Webinar available to all contractors and BHRS staff to address documentation errors identified by DHCS. Presentation slides, a documentation refresher guide and video were sent to all providers. Supervisors were requested to review these materials with staff.

3. Ongoing Required Online Training BHRS implemented required training for all new staff on medical necessity, writing progress notes, and billing.

4. Annual Live Training- Four different live trainings on billing and writing progress notes related to medical necessity are provided yearly. Monthly live documentation where providers can ask questions related to documentation.

5. Internal Audit- BHRS has implemented an audit program for where medical necessity is reviewed and billing/charts are disallowed if they do not meet medical necessity.

Proposed Evidence/Documentation of Correction

1. Letters were sent to providers/programs concerning recoupments due to medical necessity.

Attach1_1-A-3b1-Letter_MN_PHI

Attach2_1-A-3b-Letter2_MN_PHI

Attach3_1-A-3b2-Letter_MN_PHI

Plan of Correction Evidence of Action Meeting Agenda/Minutes due to QM 1/17/2020.

2. See: Presentation slides from live training, training schedule, attendance log, Documentation Refresher guide, and email sent to all staff informing them of training materials.

Attach4_TriennialMediCalChartAudit_11.20

See slides 11,12,13,14 PHI

Attach5_QMWebinarTrainingSchedule2020

Attach6_TrainingAttendenceJune-Nov2020

Attach7_DocumentationRefresher8.2020

See page 8,9

Attach8_Email_sent to_providers_Audit

3. See training attendance logs and new staff training requirements.

Attach6_TrainingAttendenceJune-Nov2020

Attach9_REQUIRED_ONLINE_TRAININGS

4. See attendance logs and live training schedules.

Attach6_TrainingAttendenceJune-Nov2020

Attach13 TrainingAttendenceJan-May2020

Attach5_QMWebinarTrainingSchedule2020

Attach11 QMWebinarTrainingSchedule2021

5. See Audit Tool and Internal Audit Finding summary for 2020 to date

Attach12_SanMateoAuditTool

See question 43

Attach10_InternalAuditFY2021_ToDate_PHI

See question 43

Implementation Timeline:

1. Letter Sent to Providers 12/3/2020. Provider's Plan of Correction Evidence of Action due to QM 1/17/2021

2. Completed 11/18/2020

3. Fully Implemented /Ongoing

4. Fully Implemented /Ongoing

5. Fully Implemented /Ongoing

Requirement

ASSESSMENTS

DHCS Finding

FINDING 2A:

Assessments were not completed in accordance with regulatory and contractual requirements, specifically: One or more assessments were not completed within the initial timeliness specified in the MHP's written documentation standards.

CORRECTIVE ACTION PLAN 2A:

The MHP shall submit a CAP that:

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

2) Planned Specialty Mental Health Services are not claimed in the absence of an assessment that substantiates those services.

Corrective Action Description

1 Providers/programs were notified of audit results and re-training occurred- BHRS informed program management and providers of assessments that were missing required elements. Programs were required to meet and train staff.

2 Live Training -BHRS QM provided a Webinar available to all contractors and BHRS staff to address documentation errors identified by DHCS. Presentation slides, a guide and video were sent to all providers. Supervisors were requested to review these materials with staff.

3 Ongoing Required Online Training BHRS implemented required training for all new staff conducting assessments.

4 Annual Live Training- Two live assessment trainings are provided yearly. Monthly live documentation training occurs (Ask QM Q&A) where providers can ask questions about documentation including assessment requirements.

5 Internal Audit- BHRS has an ongoing audit program that audits assessments.

Auditors rate several assessment related questions.

The services were/are voided/self-disallowed if the answer is:

Q 16. Is there an Assessment Gap that resulted in Disallowance? Is answered, Yes

Q 17. Is there a current assessment (<3 years old that covers the audit period)? Is answered, No

6 Monthly Documentation reports are sent to all SDMC programs that informs providers of assessment due dates.

Proposed Evidence/Documentation of Correction

1 Letters were sent to providers/programs concerning late assessments.

Attach14-2_A-Letter_MN_PHI

Plan of Correction Evidence of Action Meeting Agenda/Minutes due to QM 1/17/2020.

2 See: Presentation slides from live training, training schedule, attendance log, and Documentation Refresher guide.

Attach4_TriennialMediCalChartAudit_11.20

See slides 20,21,22,23 PHI

Attach5_QMWebinarTrainingSchedule2020

Attach6_TrainingAttendenceJune-Nov2020

Attach7_DocumentationRefresher8.2020

See page 1,2,6

3 See training attendance log and new staff training requirements.

Attach6_TrainingAttendenceJune-Nov2020

Attach9_REQUIRED_ONLINE_TRAININGS

4 See attendance logs, live training schedules, and assessment presentation slides.

Attach6_TrainingAttendenceJune-Nov2020

Attach13_TrainingAttendenceJan-May2020

Attach5_QMWebinarTrainingSchedule2020

Attach11 QMWebinarTrainingSchedule2021

Attach15_AssessmentMentalHealth2020

5 See Audit Tool and internal Audit Finding summary for 2020 to date.

Attach12_SanMateoAuditTool

See questions 15, 16, 17, 43

Attach10 InternalAuditFY20-21_ToDate_PHI

See questions 15, 16, 17, 43

6 Documentation Tracking Report for County Programs and Assessment Coming Due and Overdue Status Report sent to programs:

Attach16_MontlhyTrackingReport-County

Attach17Assessment_Coming_Due_Example_PHI

Implementation Timeline:

1 Letter Sent to Providers 12/3/2020. Providers' Plan of Correction Evidence of Action due to QM 1/17/2021

2 Completed 11/18/2020

3 Fully Implemented /Ongoing

4 Fully Implemented /Ongoing

5 Fully Implemented /Ongoing

6 Fully Implemented /Ongoing

Requirement

ASSESSMENTS

DHCS Finding

FINDING 2B:

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

CORRECTIVE ACTION PLAN 2B:

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

Corrective Action Description

1 Providers/programs were notified of audit results and re-training occurred- BHRS informed program management and providers of assessments that were missing required elements. Programs were required to meet and train staff.

2 Live Training -BHRS QM provided a Webinar available to all contractors and BHRS staff to address documentation errors identified by DHCS. Presentation slides, a documentation refresher guide and video were sent to all providers. Supervisors were requested to review these materials with staff.

3 Ongoing Required Online Training BHRS implemented required training for all new staff on assessments.

4 Annual Live Training- Two live assessment trainings are provided yearly. Monthly live Documentation training occurs (Ask QM Q&A) where providers can ask questions about documentation including assessment requirements.

5 Internal Audit- BHRS has an ongoing audit program that audits assessments against requirements. Providers are informed of assessment missing requirement information.

Proposed Evidence/Documentation of Correction

1 Letters were sent to providers/programs concerning assessments missing required elements.

Attach14-2_A-Letter_MN_PHI

Plan of Correction Evidence of Action Meeting Agenda/Minutes due to QM 1/17/2020.

2 See: Presentation slides from live training, training schedule, attendance log, and Documentation Refresher guide.

Attach4_TriennialMediCalChartAudit_11.20

See slides 20,21,22,23 PHI

Attach5_QMWebinarTrainingSchedule2020

Attach6_TrainingAttendenceJune-Nov2020

Attach7_DocumentationRefresher8.2020

See page 1,2,6

3 See training attendance log and new staff training requirements.

Attach6_TrainingAttendenceJune-Nov2020

Attach9_REQUIRED_ONLINE_TRAININGS

4 See attendance logs, live training schedules, and assessment presentation slides.

Attach6_TrainingAttendenceJune-Nov2020

Attach13_TrainingAttendenceJan-May2020

Attach5_QMWebinarTrainingSchedule2020

Attach11QMWebinarTrainingSchedule2021

Attach15_AssessmentMentalHealth2020

5 See Audit Tool and internal Audit Finding summary for 2020 to date.

Attach12_SanMateoAuditTool

See questions 20,21,22,23,24

Attach10_InternalAuditFY20-21_ToDate_PHI

See questions 20,21,22,23,24

Attach18_Email_Provider_Missing_Assessment_Information PHI

Implementation Timeline:

1 Letters Sent to Providers 12/3/2020

2 Provider's Plan of Correction Evidence of Action due to QM 1/17/2021

3 Completed 11/18/2020

4 Fully Implemented /Ongoing

5 Fully Implemented /Ongoing

Requirement

MEDICATION CONSENT

DHCS Finding

FINDING 3A:

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

FINDING 3B:

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

1) Reasonable alternative treatments available.

2) Duration of taking each medication.

FINDING 3C:

Medication Consent(s) in the chart sample did not include the signature of the provider of service (or electronic equivalent) that includes the provider's professional degree, licensure, job title, and/or the date the provider completed and entered the document into the medical record. Specifically:

• The type of professional degree, licensure, or job title of person providing the service.

CORRECTIVE ACTION PLAN 3A:

The MHP shall submit a CAP to address actions it will implement to ensure that a written medication consent forms is obtained and retained for each medication prescribed and administered under the direction of the MHP.

CORRECTIVE ACTION PLAN 3B:

The MHP shall submit a CAP 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 PLAN 3C:

The MHP shall submit a CAP that describes how the MHP will ensure that all Medication Consents include the Provider's signature (or electronic equivalent) that includes professional degree, licensure or title.

Corrective Action Description

1 Providers/programs were notified of audit results and re-training occurred- BHRS informed program management and providers of assessments that were missing required elements. Programs were required to meet and train staff.

2 Live Training to occur for all MD/NP on all issues related to medication consents.

3 Internal Audit- BHRS has an ongoing audit program that audits for medication consent requirements. Providers are notified of medication consent issues.

Proposed Evidence/Documentation of Correction

1 Letters were sent to providers/programs concerning medication consents that did not meet all requirements Attach19_MedicationConsentsLetter PHI

Plan of Correction Evidence of Action Meeting Agenda/Minutes due to QM 1/15/2020

2 Email sent to Medical Director Attach20_POC_MedicationConsents_Due by 1.31.21 PHI

3 See Audit Tool and internal Audit Finding summary for 2020 to date:

Attach12_SanMateoAuditTool

See question 12, 13

Attach10_InternalAuditFY20-21_ToDate_PH

See question 12, 13

Implementation Timeline:

1. Letter Sent to Providers 12/3/2020. Provider's Plan of Correction Evidence of Action due to QM 1/15/2021

2. 1/ 31/2021

3. Fully Implemented /Ongoing

Requirement

CLIENT PLANS

DHCS Finding

FINDING 4A-2:

The medical record did not include services that were sufficient to adequately "achieve the purpose for which the services are furnished".

FINDING 4A-2a:

Services claimed and documented on the beneficiary's progress notes were not sufficient and consistent in amount, duration or scope with those documented on the beneficiary's current Client Plan.

CORRECTIVE ACTION PLAN 4A-2:

The MHP shall submit a CAP that describes how the MHP will ensure that all Client Plans and actual services provided include interventions sufficient to reasonably attain the purpose and goals documented on the Plan.

CORRECTIVE ACTION PLAN 4A-2a:

The MHP shall submit a CAP that describes how the MHP will ensure that services are provided in the amount, duration, and scope as specified in the Individualized Client Plan for each beneficiary.

Corrective Action Description

1 Providers/programs were notified of audit results and re-training occurred- BHRS informed program management and providers of client plan that were missing required elements. Programs were required to meet and train staff.

2 Live Training -BHRS QM provided a Webinar available to all contractors and BHRS staff to address documentation errors identified by DHCS. Presentation slides, a documentation refresher guide and video were sent to all providers. Supervisors were requested to review these materials with staff.

3 Ongoing Required Online Training BHRS implemented required training for all new staff on Client Plans.

4 Annual Live Training- training is provided yearly on client plans. Monthly live Documentation training occurs were providers can ask questions about documentation including client plan requirements.

5 Internal Audit- BHRS has an ongoing audit program that audits client plans.

Proposed Evidence/Documentation of Correction

1 Letters were sent to provider/programs concerning client plans not meeting requirements.

Attach29-4A-Letter_Interventions_PHI

Plan of Correction Evidence of Action Meeting Agenda/Minutes due to QM 1/17/2020

2 See Presentation slides from live training, training schedule, attendance log, and Documentation Refresher guide.

Attach4_TriennialMediCalChartAudit_11.20

See slides, 15, 16, 17, 18, 19 PHI

Attach5_QMWebinarTrainingSchedule2020

Attach6_TrainingAttendenceJune-Nov2020

See page 2,4,5,6

Attach7_DocumentationRefresher8.2020

3 See training attendance log and new staff training requirements.

Attach6_TrainingAttendenceJune-Nov2020

Attach9_REQUIRED_ONLINE_TRAININGS

4 See attendance logs, live training schedules, and assessment presentation slides.

Attach22_ClientPlanTraining

Attach6_TrainingAttendenceJune-Nov2020

Attach13_TrainingAttendenceJan-May2020

Attach5_QMWebinarTrainingSchedule2020

Attach11_QMWebinarTrainingSchedule2021

5 See Audit Tool and internal Audit Finding summary for 2020 to date

Attach12_SanMateoAuditTool

See questions 26,32,33,35,36,37,39,43

Attach10_InternalAuditFY20-21_ToDate_PHI

See questions 26,32,33,35,36,37,39,43

Implementation Timeline:

1. Letter Sent to Providers 12/3/2020

2. Provider's Plan of Correction Evidence of Action due to QM 1/17/2021

3. Completed 11/18/2020

4. Fully Implemented /Ongoing

5. Fully Implemented /Ongoing

6. Fully Implemented /Ongoing

Requirement

CLIENT PLANS

DHCS Finding

FINDING 4B-1:

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

FINDING 4B-2:

One or more client plan(s) was not updated at least annually and/or when there were significant changes in the beneficiary's condition.

FINDING 4C:

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

• One or more proposed intervention did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded.

One or more proposed intervention did not include an expected frequency or frequency range that was specific enough.

CORRECTIVE ACTION PLAN 4B-1:

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

1) Client plans are completed prior to the provision of planned services.

2) Planned services are not claimed when the service provided is not included on a current Client Plan.

CORRECTIVE ACTION PLAN 4B-2:

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

1) Client plans are completed prior to the provision of planned services.

2) Client plans are updated at least on an annual basis, as required by the MHP Contract with theDepartment, and within the timelines and frequency specified in the MHP's written documentation standards.

3) Planned services are not claimed when the service provided is not included on a current Client Plan.

4) Client Plans are reviewed and updated whenever there is a significant change in the beneficiary's mental health condition.

CORRECTIVE ACTION PLAN 4C:

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

1) Mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or modality of service (e.g. "therapy", "medication", "case management", etc.).

2) Mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

Corrective Action Description

1 Providers/programs were notified of audit results and re-training occurred- BHRS informed program management and planned services provided without a current valid client plan.

2 Live Training -BHRS QM provided a Webinar available to all contractors and BHRS staff to address documentation errors identified by DHCS. Presentation slides, a documentation refresher guide and video were sent to all providers. Supervisors were requested to review these materials with staff.

3 Ongoing Required Online Training BHRS implemented required training for all new staff on client plans.

4 Monthly Live Training- Monthly trainings address the requirement of a client plan and assessment prior to the provision of planned services (Ask QM Q&A).

5 Internal Audit- BHRS has an ongoing audit program that audits for client plan completion prior to planned services and the inclusion of planned services on treatment

plan, and timely completion of client plans. Providers are informed of issues with their client plans and are asked to make needed corrections.

6 Monthly Documentation reports are sent to all SDMC programs that informed providers of client plan due dates.

Proposed Evidence/Documentation of Correction

1 Letters were sent to provider/program concerning recoupments due to client plans.

Attach234B 1_LetterPlannedServiceNoPLan_PHI

Plan of Correction Evidence of Action Meeting Agenda/Minutes due to QM 1/15/2020

2 See Presentation slides from live training, training schedule, attendance log, and Documentation Refresher guide.

Attach4_TriennialMediCalChartAudit_11.20

See slides, 15, 16, 17, 18, 19 PHI

Attach5_QMWebinarTrainingSchedule2020

Attach6_TrainingAttendenceJune-Nov2020

Attach7_DocumentationRefresher8.2020

See page 2,4,5,6

3 See training attendance log and new staff training requirements.

Attach6_TrainingAttendenceJune-Nov2020

Attach9_REQUIRED_ONLINE_TRAININGS

4 See attendance logs, live training schedules, and assessment presentation slides.

Attach6_TrainingAttendenceJune-Nov2020

Attach13_TrainingAttendenceJan-May2020

Attach5_QMWebinarTrainingSchedule2020

Attach11_QMWebinarTrainingSchedule2021Attach22_ClientPlanTraining

5 See Audit Tool and Internal Audit Finding summary for 2020 to date

Attach12_SanMateoAuditTool

See questions 35, 37, 39, 43

Attach10_InternalAuditFY20-21_ToDate_PHI

See questions 35, 37, 39, 43

6 Documentation Tracking Report County Programs and Client Plan Coming Due and Overdue Status Report sent to programs:

Attach16_MontlhyTrackingReport-County

Attach21_ClientPlan_Coming_Due_Example PHI

Implementation Timeline:

1. Letter Sent to Providers 12/3/2020

Provider's Plan of Correction Evidence of Action due to QM 1/15/2021

2. Completed 11.18.2020

3. Fully Implemented /Ongoing

4. Fully Implemented /Ongoing

5. Fully Implemented /Ongoing

6. Fully Implemented /Ongoing

Requirement

CLIENT PLANS

DHCS Finding

FINDING 4H:

One or more Client Plan did not include signature that includes the person's professional degree, licensure, job title, relevant identification number, or date the documentation was entered into the medical record.

CORRECTIVE ACTION PLAN 4H:

The MHP shall submit a CAP that describes how the MHP will ensure that all documentation includes the Provider signature (or electronic equivalent) with the professional degree, licensure, or job title.

Corrective Action Description

1 There was an error in one staff person's credential in the EMR. The error was corrected.

2 The error occurred due to a process error with retired staff.

The billing department was informed of this process error and has been informed that all staff being set up in the EMR require a recredentialing (included retired staff).

Proposed Evidence/Documentation of Correction

1. The error was corrected, and the providers credentials have been verified.

2. The Billing department was informed that all providers credentials must be verified prior to being set up in the EMR.

This item will be addressed at the BHRS Credentialing Meeting 1/21/2021 to confirm that no providers are being set up in the EMR without verifying credentials.

Attach24_ConfirmCredentialingProcess

Implementation Timeline:

1. Completed

2. 1/21/2021

Requirement

PROGRESS NOTES

DHCS Finding

FINDING 5B:

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

CORRECTIVE ACTION PLAN 5B:

The MHP shall submit a CAP that describes how the MHP will ensure that progress notes document:

• Timely completion and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.

• The provider's/ providers' professional degree, licensure or job title.

Corrective Action Description

1 Providers/programs were notified of audit results and re-training occurred- BHRS informed program management and providers of late progress notes and progress notes missing credentials.

2 Live Training -BHRS QM provided a Webinar available to all contractors and BHRS staff to address documentation errors identified by DHCS. Presentation slides, a documentation refresher guide and video were sent to all providers. Supervisors were requested to review these materials with staff.

3 Ongoing Required Online Training BHRS implemented required training for all new staff progress note requirements.

4 Live Training-Progress note trainings are held regularly and address timeliness.

5 Internal Audit- BHRS has an ongoing audit program that reviews progress notes timeliness.

6 Monthly Documentation reports will be sent to all SDMC programs that informed providers of progress note timeliness.

Proposed Evidence/Documentation of Correction

1 Letters were sent to provider/program concerning late progress notes and providers signatures.

Attach25-4H-Letter_PN_Creditials_PHI

Attach26-4H-Letter_PN_LatePN_PHI

Plan of Correction Evidence of Action Meeting Agenda/Minutes due to QM 1/31/2020

2 See Presentation slides from live training, training schedule, attendance log, and Documentation Refresher guide.

Attach4_TriennialMediCalChartAudit_11.20 PHI

Attach5_QMWebinarTrainingSchedule2020

Attach6_TrainingAttendenceJune-Nov2020

Attach7_DocumentationRefresher8.2020

See page 7

3 See training attendance log and new staff training requirements.

Attach6_TrainingAttendenceJune-Nov2020

Attach9_REQUIRED_ONLINE_TRAININGS

4 See attendance logs, live training schedules, and assessment presentation slides.

Attach6_TrainingAttendenceJune-Nov2020

Attach13_TrainingAttendenceJan-May2020

Attach5_QMWebinarTrainingSchedule2020

Attach11_QMWebinarTrainingSchedule2021

5 See Audit Tool and internal Audit Finding summary for 2020 to date

Attach12_SanMateoAuditTool

See question 43, 45

Attach10 InternalAuditFY20-21_ToDate_PHI

See question 43, 45

6 Attach27_Progress_NoteTimeliness_Report

Implementation Timeline:

1. Letter Sent to Providers 12/8/2020

Provider's Plan of Correction Evidence of Action due to QM 1/16/2021 and 1/31/2021

2. Completed 11/18/2020

3. Fully Implemented /Ongoing

4. Fully Implemented /Ongoing

5. Fully Implemented /Ongoing

6. 1/31/2021

Requirement

PROGRESS NOTES

DHCS Finding

FINDING 5C:

Documentation of services provided to, or on behalf of, a beneficiary by one or more persons at one point in time did not include all required components. Specifically: Progress notes did not accurately document the number of group participants in the group.

CORRECTIVE ACTION PLAN 5C:

The MHP shall submit a CAP that describes how the MHP will ensure that progress notes contain the actual number of clients participating in a group activity, the number and identification of all group provider/facilitators, the correct type of service (e.g., Group Rehabilitation or Group Psychotherapy), and date of service.

Corrective Action Description

1. Providers/programs were notified of audit results and re-training occurred- BHRS informed program management and providers of billing errors related to group billing. Programs were required to meet and train staff.

2. Live Training -BHRS QM provided a Webinar available to all contractors and BHRS staff to address documentation errors identified by DHCS. Presentation slides, a documentation refresher guide and video were sent to all providers. Supervisors were requested to review these materials with staff.

3. Ongoing Required Online Training BHRS implemented required training for all new staff on group progress notes and billing.

4. Annual Live Training- Annual trainings is provided concerning group billing and progress notes. Monthly live Documentation training where providers can ask questions related to documentation (Ask QM Q&A).

5. Internal Audit- BHRS has implemented an audit program for correct group service type and group services.

Proposed Evidence/Documentation of Correction

1. Letters were sent to provider/program concerning group progress note issues.

Attach28-5C-Letter_Groups_PHI Plan of Correction Evidence of Action Meeting Agenda/Minutes due to QM 1/17/2020

2. See Presentation slides from live training, training schedule, attendance log, and Documentation Refresher guide.

Attach4_TriennialMediCalChartAudit_11.20

See slides 11,12,13,14 PHI

Attach5_QMWebinarTrainingSchedule2020Attach6_TrainingAttendenceJune-Nov2020

Attach7_DocumentationRefresher8.2020

See page 7

3. See training attendance log and new staff training requirements.

Attach6_TrainingAttendenceJune-Nov2020

Attach9_REQUIRED_ONLINE_TRAININGS

4. See attendance logs and live training schedules.

Attach29_Groups_Training

Attach6_TrainingAttendenceJune-Nov2020

Attach13_TrainingAttendenceJan-May2020

Attach5_QMWebinarTrainingSchedule2020

Attach11 QMWebinarTrainingSchedule2021

5. See Audit Tool and internal Audit Finding summary for 2020 to date

Attach12_SanMateoAuditTool

See question 46, 47

Attach10_InternalAuditFY20-21_ToDate_PHI

See question 46, 47

Implementation Timeline:

1. Letter Sent to Providers 12/8/2020

Provider's Plan of Correction Evidence of Action due to QM 1/31/2021

2. Completed 11/18/2020

3. Fully Implemented /Ongoing

4. Fully Implemented /Ongoing

5. Fully Implemented /Ongoing

Requirement

PROGRESS NOTES

DHCS Finding

FINDING 5D:

Progress notes were not documented according to the frequency requirements specified in the MHP Contract. Specifically: There was no progress note in the medical record for the service(s) claimed.

CORRECTIVE ACTION PLAN 5D:

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

1) Ensure that all Specialty Mental Health Services claimed are:

a) Documented in the medical record.

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

c) Claimed to provider who actually provided the services.

2) Ensure that all progress notes:

a) Are accurate, complete and legible and meet the documentation requirements described in the MHP Contract with the Department.

b) Describe the type of service or service activity, the date of service and the amount of time to provide the service, as specified in the MHP Contract with the Department.

c) Are completed within the timeline and frequency specified in the MHP Contract with the Department, and as specified in the MHP's written documentation standards.

Corrective Action Description

1. Providers/programs were notified of audit results and re-training occurred- BHRS informed program management and providers of billing errors related to progress notes requirement. Programs were required to meet and train staff.

2. Pro-fee Claims -Many progress notes rated as missing or have an issue with the claim were hospital claims. A Plan of Correction was issued to the hospital in question. Audit protocol was developed to conduct ongoing audits of pro-fee claims.

3. Live Training -BHRS QM provided a Webinar available to all contractors and BHRS staff to address documentation errors identified by DHCS. Presentation slides, a documentation refresher guide and video were sent to all providers. Supervisors were requested to review these materials with staff.

4. Ongoing Required Online Training BHRS implemented required training for all new staff on medical necessity, progress notes, and billing.

5. Annual Live Training- Four live trainings addressing billing and progress notes related to medical necessity provided yearly. Monthly live Documentation training where providers can ask questions related to documentation.

6. Internal Audit- BHRS has implemented an audit program for where progress note requirements are not met.

Proposed Evidence/Documentation of Correction

1. Letters were sent to provider/program considering progress note requirements.

Attach234B-1_Letter_PlannedService_NoPLan_PHI

2. Attach30-5D-Letter_ProgressNotes_PHI.

Attach31_ProfeeAuditTracking2021

3. See Presentation slides from live training, training schedule, attendance log, and Documentation Refresher guide.

Attach4_TriennialMediCalChartAudit_11.20

See slides 11,12,13,14 PHI

Attach5_QMWebinarTrainingSchedule2020

Attach6_TrainingAttendenceJune-Nov2020

Attach7_DocumentationRefresher8.2020

See page 6,7,8,9

Attach 8_Email send to all providers

4. See training attendance log and new staff training requirements

Attach6_TrainingAttendenceJune-Nov2020

Attach9_REQUIRED_ONLINE_TRAININGS

5. See attendance logs and live training schedules.

Attach6_TrainingAttendenceJune-Nov2020

Attach13_TrainingAttendenceJan-May2020

Attach5_QMWebinarTrainingSchedule202

Attach11 QMWebinarTrainingSchedule2021

6. See Audit Tool and internal Audit Finding summary for 2020 to date

Attach12_SanMateoAuditTool

See question 45

Attach10InternalAuditFY20-21_ToDate_PHI

See question 45

Implementation Timeline:

1. Letter Sent to Providers 12/3/2020

Provider's Plan of Correction Evidence of Action due to QM 1/31/2021

2. 1/31/2021

3. Completed 11/18/2020

4. Fully Implemented /Ongoing

5. Fully Implemented /Ongoing

6. Fully Implemented /Ongoing

DHCS Finding

FINDING 6A:

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.

CORRECTIVE ACTION PLAN 6A:

The MHP shall submit a CAP that describes how it will ensure that:

1) Written documentation is in place describing the process for determining and documenting eligibility and need for ICC Services and IHBS.

2) Training is provided to all staff and contract providers who have the responsibility for determining eligibility and need for ICC and IBHS.

3) Each beneficiary under age 22 who is authorized to receive Specialty Mental Health Services also receives an individualized determination of eligibility and need for ICC Service and IHBS prior to or during the development of the beneficiary's Initial Client Plan.

Corrective Action Description

1. Policy and procedure development (item 1 & 3)

1. BHRS Quality Management and Youth Services formed a workgroup to address this plan of correction Item following the Audit.

2. Workgroup will l develop a formal policy and procedure for assessing clients under the age of 21 to be screened for ICC and IHBS services eligibility during the initial Assessment and at reassessment.

3. Policy and Procedure will specify 1)Eligibility criteria and documentation standards 2)Authorization and Referral process for ICC and IHBS. 3) Reassessment for ICC and IHBS services timeline.

4. BHRS will incorporate ICC/IHBS/TFC eligibility screening questions to the BHRS Youth Assessment.

5. BHRS will update the Avatar Treatment plan to specify frequency, duration and intervention specifically for IHBS and ICC services.

2. Training (item 2)

1. BHRS will develop training specifically targeting ICC and IHBS service eligibility criteria, referral process, authorization, treatment planning, and reevaluation.

2. Training will include instruction on coding services properly.

3. Training will be provided to all staff and contractors who work with youth under 21 who perform screening, assessment and treatment planning

Proposed Evidence/Documentation of Correction

1. Evidence for 1.1

• Attach32_TFC_ICC_IHBS Workgroup Agenda & Meeting Minutes.zip

2. BHRS will submit the following evidence for 1a-d

a. Policy and Procedures developed for ICC/IHBS Screening, Referral and authorization.

b. Screening and Authorization documentation templates

c. Sample of updated Assessment documentation

d. Sample of updated treatment plan documentation

3. BHRS will submit the following evidence for 2a-b

a. Copy of training materials and training announcement

b. Staff training attendance log

Implementation Timeline:

1. Workgroup began on 9/23/2019 & BHRS had TA call with DHCS and CDSS on 11/18/2020

2. Policy and procedures will be completed by 5/31/2021

3. Updates to assessment and Treatment plan forms completed by 6/30/2021.

4. Training of staff and contractors by 8/30/2021