System Review Findings Report
Contra Costa County Mental Health Plan
Fiscal Year 2016/2017
RESULTS SUMMARY: SYSTEM REVIEW

SYSTEM REVIEW SECTION	TOTAL ITEMS REVIEWED	SURVEY ONLY ITEMS	TOTAL FINDINGS PARTIAL or OOC	PROTOCOL QUESTIONS OUT-OF-COMPLIANCE (OOC) OR PARTIAL COMPLIANCE	IN COMPLIANCE PERCENTAGE FOR SECTION
ATTESTATION	5	0	0/5		100%
SECTION A: NETWORK ADEQUACY AND ARRAY OF SERVICES	14	2	0/14		100%
SECTION B: ACCESS	48	5	4/48	5b2, 5d, 9a2, 9a4,	92%
SECTION C: AUTHORIZATION	26	; 2	5/26	1c, 2d, 4b, 6d, 6e	81%
SECTION D: BENEFICIARY PROTECTION	25	0	6/25	2a3, 2b, 3a1, 3a2, 3b, 4c1	76%
SECTION E: FUNDING, REPORTING & CONTRACTING REQUIREMENTS			NOT APPLICABLE		
SECTION F: INTERFACE WITH PHYSICAL HEALTH CARE	6	0	0/6		100%
SECTION G: PROVIDER RELATIONS	6	0	1/6	3b	83%

SECTION H: PROGRAM INTEGRITY	19	4	1/19	4a	95%
SECTION I: QUALITY IMPROVEMENT	30	8	0/30		100%
SECTION J: MENTAL HEALTH SERVICES ACT	21	0	0/21		100%
TOTAL ITEMS REVIEWED	**200**	**16**	**17**		

OVERALL SYSTEM REVIEW COMPLIANCE

Total Number of Requirements Reviewed	216 (with 5 Attestation items)			
Total Number of SURVEY ONLY Requirements	16 (NOT INCLUDED IN CALCULATIONS)			
Total Number of Requirements Partial or OOC	17		OUT OF 200	
	IN		OOC/Partial	
OVERALL PERCENTAGE OF COMPLIANCE	(# IN/200)	**91%**	(# OOC/200)	**9%**

System Review Findings Report
Contra Costa County Mental Health Plan
Fiscal Year 2016/2017
FINDINGS

SECTION B: ACCESS

PROTOCOL REQUIREMENTS

B5. Regarding written materials:

B5a. Does the MHP have written informing materials in alternative formats in English and the threshold language(s)?

B5b. 1) Does the MHP inform beneficiaries that information is available in alternative
2) Does the MHP inform beneficiaries how to access alternative formats?

FINDINGS
The MHP does not have a mechanism to inform beneficiaries of how to access alternative formats. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: The Beneficiary Handbook page 3. The handbook stated

that materials are available in English and Spanish in written and taped formats. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP had no method of informing the beneficiary how to access informing materials in alternative formats. Protocol question B5b2 is deemed OOC.

1. ***CONTRA COSTA PLAN OF CORRECTION B5b2***

The MHP has made revisions to its informing materials to make this information more readily available to its beneficiaries. Specifically, the Contra Costa section of the Medi-Cal Guide book has been revised to clearly speak to this requirement. Additionally, MHP has created and required the posting of the Informing Material Poster in all its waiting rooms for both County and contracted providers. All providers are required to display this poster both in English and in the County's threshold language, Spanish. This poster succinctly informs all Contra Costa beneficiaries of important information including that MHP's informing materials are available in alternate formats. The Informing Materials Policy (Policy 827) has been revised to reflect these new requirements.

See Appendix A for supporting documentation

PROTOCOL REQUIREMENTS

B5c. Do these written materials take into consideration persons with limited vision?
B5d. Do these written materials take into consideration persons with limited reading proficiency (e.g., 6th grade reading level)?

FINDINGS

The MHP did not furnish evidence its written materials take into consideration persons with limited vision and/or persons with limited reading proficiency (e.g., 6th grade reading level). DHCS reviewed the following documentation presented by the MHP as evidence of compliance: The MHP provided evidence of assessing the reading levels for the grievance form, the appeal request, and change of provider form. The reading levels were recorded at grades 7.1, 10.0, and 10.9. The reading level assessment was performed in Microsoft Word after this question was asked by the DHCS team during the review. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the assessments of the identified documents to determine reading levels were not performed as materials were being developed or modified over the span of the triennial review period. Protocol question B5d is deemed OOC.

2. ***CONTRA COSTA PLAN OF CORRECTION B5d***

To address the needs of beneficiaries with limited vision, MHP offers its informing materials in large print and audio formats. This information is communicated to the beneficiaries through the Medi-Cal Guidebook, Policy 827 as well as the Informing Materials Poster which the Plan requires to be posted both in English and Spanish in all its waiting rooms, by both County and contracted providers.

MHP has conducted several assessments of the reading level for its informing materials. MHP is unable to meet the 6th grade proficiency reading level if it is to meet the requirements under 42 CFR 438.10(c)(4)(i)(ii) which states:

> For consistency in the information provided to enrollees, the State must develop and require each MCO, PIHP, PAHP and PCCM entity to use:
>
> **(i)** Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care; and
>
> **(ii)** Model enrollee handbooks and enrollee notices.

A reading level assessment of several of these terminologies in a sentence was performed through Microsoft Word. It determined the reading level at 16.0 (see attached). This assessment shows how the usage of the prescribed definitions for managed care terminology can render the Plan out of compliance with the 6th grade reading level proficiency. In order to comply with the federal rules and the terms of its contract with DHCS, while meeting the needs of its beneficiaries, MHP has developed and required posting of the Informing Materials Poster in both English and Spanish. This poster is available in all waiting rooms, and informs our beneficiaries that if they have trouble understanding any of the informing materials, a staff person will be assigned to help them, and they may also call the Access Line for assistance. See attached Informing Materials poster.

See Appendix B for supporting documentation

PROTOCOL REQUIREMENTS

B9a. Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:

1) Does the MHP provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages Spoken by beneficiaries of the county?

2) Does the toll-free telephone number provide 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) Does the toll-free telephone number provide information to beneficiaries about services needed to treat a beneficiary's urgent condition?

4) Does the toll-free telephone number provide information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes?

The DHCS review team made seven (7) calls to test the MHP's 24/7 toll-free line.

FINDINGS

Protocol Question	Test Call Result's							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
9a-1	IN	IN	IN	IN	IN	IN	IN	100%
9a-2	IN	IN	OOC	OOC	IN	N/A	N/A	60%
9a-3	IN	IN	IN	IN	IN	IN	IN	100%
9a-4	N/A	N/A	N/A	N/A	N/A	OOC	OOC	0%

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Four MHP test call summaries, the Test Call scenarios list, the County Script for Access Line calls, and the Access Line Script for Optum (the Access Line after-hours contracted answering service). However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, compliance was determined by the seven (7) DHCS test calls. Protocol questions B9a1 and B9a3 are deemed in compliance, protocol question B9a2 is deemed in partial compliance, and protocol question B9a4 is deemed OOC.

3. CONTRA COSTA PLAN OF CORRECTION B9a2

The Access Line was reconfigured in June 2017 to have licensed mental health clinicians answer live calls, rather than clerks, as has been the practice for the past two years. The clerks were not equipped with the information needed to provide information about accessing SMHS, including whether medical necessity criteria are met, as this was to be provided when the caller was transferred to a clinician or when the clinician returned the caller's phone call. Now that the clinicians will be answering the majority of incoming calls, they will be able to provide information about accessing SMHS. In the event a clerk answers the call if no clinicians are available, the Access Line created an Access Line Clerk tip sheet and phone script for general information about accessing SMHS. This phone script will be supplied to the Optum (Access after-hours contractor)

as well, with a request of training Optum staff on the plan/script within 60 days and a sign-in sheet by staff attendees to confirm the training occurred. In addition, the MHP will increase the number of test calls made to 15 calls per quarter, including 2 calls in Spanish, in order to ensure compliance.

See Appendix C for supporting documentation

4. CONTRA COSTA PLAN OF CORRECTION B9a4

The Access Line has routinely given out the Quality Improvement Coordinator's contact information in the past, and this was found in compliance in previous audits. To address this item being out of compliance, the Access Line has created Access Line tip sheet for grievances, appeals, and change of provider requests and a phone script for beneficiary problem resolution and the State Fair Hearing process to assist the Access clinician in providing the correct information to the caller, in addition to providing them with the contact information for the Quality Improvement Coordinator. Included is the how callers can access the grievance form online and have the ability to send the form and envelope out. This phone script will be supplied to Optum as well. Access Line has requested that Optum staff be trained within 60 days in guiding callers on using and accessing the problem resolution and fair hearing processes. We have requested that Optum supply a staff sign-in sheet once Optum staff is trained in order to validate that the training occurred. In addition, the MHP will increase the number of test calls made to 15 calls per quarter, including 2 calls in Spanish, in order to ensure compliance.

See Appendix D for supporting documentation

PROTOCOL REQUIREMENTS

B10. Regarding the written log of initial requests for SMHS:

B1ba. Does the MHP maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing?

B10b. Does the written log(s) contain the following required elements:

1) Name of the beneficiary?
2) Date of the request?
3) Initial disposition of the request?

FINDINGS

The MHP did not furnish evidence 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: Access Call Logs. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, two of the seven test calls were not on the log.

The table below details the findings:

Test Call#	Date of Call	Time of Call	Log Results: Name of the Beneficiary	Log Results: Date of the Request	Log Results: Initial Disposition of the Request
1	2/2/2017	2:05pm	OUT	OUT	OUT
2	3/8/2017	11:55am	IN	IN	IN
3	3/20/2017	2:07pm	IN	IN	IN
4	3/17/2017	7:16am	IN	IN	IN
5	2/23/2017	12:47pm	OUT	OUT	OUT
Compliance Percentage			60%	60%	60%

Please note: Only calls requesting information about SMHS, including services needed to treat a beneficiary's urgent condition, are required to be logged.

Protocol questions B10b1, B10b2, and B10b3 are deemed in partial compliance.

5. CONTRA COSTA PLAN OF CORRECTION B10b1-3

The Access Line will perform ongoing internal audits of call logs to ensure appropriate logging of all calls, including the inclusion of all the required elements (beneficiary name, date of request, and relevant disposition). Audit reviews will be completed for approximately 2 calls per week (totaling 8 calls per month). Each call log will be subject to a two-step review: first by an Access Clinician, and subsequently by the Access Lead Clinician or Supervisor, who will validate the initial review and provide any necessary feedback to the relevant staff persons. The Audit review of the call logs will be documented to include the audit dates, call log reference number, and any feedback provided. Additionally, training/reminders on the logging requirements will be reviewed in monthly All-Staff Meetings, which will be documented in meeting minutes; receipt of reminders/training information will be documented via sign-in sheets completed by clinicians in attendance. The Access Line will continue correspondence with the Mental Health Administration team for ongoing feedback on test calls. Please see Appendix E for a sample of Call Log documentation.

See Appendix E for supporting documentation

SECTION C: AUTHORIZATION

PROTOCOL REQUIREMENTS

C1. Regarding the Treatment Authorization Requests {TARs) for hospital services:

C1a. Are the TARs being approved or denied by licensed mental health or waivered/registered professionals of the beneficiary's MHP in accordance with title 9 regulations?

C1b. Are all adverse decisions regarding hospital requests for payment authorization that were based on criteria for medical necessity or emergency admission being reviewed and approved in accordance with title 9 regulations by:
1) a physician, or
at the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under the psychologist's scope of practice?

C1c. Does the MHP approve or deny TARs within 14 calendar days of the receipt of the TAR and in accordance with title 9 regulations?

FINDINGS

The MHP did not furnish evidence it complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services. DHCS reviewed the MHP's authorization policy and procedure: Policy 833 Inpatient Provider Problem Resolution and Appeal; Policy 821 Adverse Decisions; and Policy 717 Prepayment Review. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the sample of 99TARs reviewed by DHCS showed that procedures followed did not meet regulatory requirements. Protocol question C1c is deemed in partial compliance. The TAR sample review findings are detailed below:

PROTOCOL REQUIREMENT		#TARS IN COMPLIANCE	#TARs OOC	COMPLIANCE PERCENTAGE
C1a	TARs approved or denied by licensed mental health or waivered/registered professionals	99	0	100%

C1b	All adverse decisions regarding hospital requests for payment authorization that were based on criteria for medical necessity or emergency admission being reviewed and approved in accordance with title 9 regulations by: 1} a physician, or at the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under the psychologist's scope of practice	99	0	100%
C1c	TARs approved or denied within 14 calendar days	90	9	90%

6. CONTRA COSTA PLAN OF CORRECTION C1c

The original TAR will be utilized as the tracking mechanism for receipt of required documents. Upon receipt of required initial documents, any deferrals of records, and any subsequent submission of requested documents, the original TAR will be date stamped by the clerk.

1. The Utilization Review Coordinator (URC) will determine the “authorization due by” date utilizing the stamped receipt date as day one (1) of the review period. If the TAR and the complete medical record are received separately, the fourteen (14) calendar day review period will start once all required documents are received.

2. The URC shall approve or recommend denial of inpatient services within fourteen (14) calendar days of the receipt of the TAR and the complete documented mental health record of hospitalization.

3. If the URC is unable to make a definitive decision to approve or recommend denial of services requested, the URC can defer the authorization pending receipt of additional documentation from the provider. The provider must submit requested documentation or corrections to the CCBHS Utilization Review Unit within fourteen (14) calendar days of receipt of deferral notification in order to obtain payment review for authorization.

The requirement of MD signature on denials of service:

1. The URC will make a recommendation for denial of requested payment for inpatient services and must be reviewed. The final decision will be made by the CCHBS Medical Director, Psychiatrist Consultant or psychiatrist designee regarding the recommended denial of service(s). Denial of service dispositions will be documented on the TAR Form, stating the reason(s) for denial of services. The CCBHS Medical Director or Psychiatrist Consultant will sign the TAR as the County authorizing agent.

Addressing the logging of NOA-Cs:

A NOA-C will be issued for the denial of inpatient services and will be logged in the NOA-C Log binder in the Utilization Review Unit.

See Appendix F for supporting documentation

PROTOCOL REQUIREMENTS

C2. Regarding Standard Authorization Requests for non-hospital SMHS:

C2a. Does the MHP have written policies and procedures for initial and continuing authorizations of SMHS as a condition of reimbursement?

C2b. Are payment authorization requests being approved or denied by licensed mental health professionals or waivered/registered professionals of the beneficiary's MHP?

C2c. For standard authorization decisions, does the MHP make an authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional days?

C2d. For expedited authorization decisions, does the MHP make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and within 3 working days following receipt of the request for service or, when applicable, within 14 calendar days of an extension?

FINDINGS

The MHP did not furnish evidence it complies with regulatory requirements regarding expedited authorization decisions for standard authorization requests (SARs) for non-hospital SMHS services. DHCS reviewed the MHP's authorization policy and procedures: Policy 706 Utilization Review SMHS Authorization Process; Policy 707 Day Treatment Authorization; and Policy 708 Utilization Review TBS. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, only Policy 708 contained an expedited authorization process, when all authorization processes should include the expedited 3 working days process. In addition, DHCS inspected a sample of twenty-three (23) SARs to verify compliance with regulatory requirements. Due to the expedited authorization process only being present in the TBS policy, Protocol question C2d is deemed OOC. The SAR sample review findings are detailed below:

	PROTOCOL REQUIREMENT	#SARS IN COMPLIANCE	#SARs OOC	COMPLIANCE PERCENTAGE
C2b	SARs approved or denied by licensed mental health professionals or waivered/registered professionals	23	0	100%
C2c	MHP makes authorization decisions and provides notice within 14 calendar days	23	0	100%
C2d	MHP makes expedited authorization decisions and provide notice within 3 working days	0	0	0

7. CONTRA COSTA PLAN OF CORRECTION C2d

1. To be in compliance with regulatory requirements, Policy 706, Utilization Review Specialty Mental Health Authorization Process, and Policy 707, Utilization Review Day Treatment Authorization, have been modified to include language regarding the 3-business-day expedited authorization/notification process.

2. Contra Costa County has included the current version of Policy 719, Authorization of Services to Foster Care, KinGAP, APP Children, and Non-Minor Dependents Living Outside of County of Origin. During the Triennial audit in April 2017, Policy 719 was reviewed in question C4b but was omitted during section C2d. However, Policy 719 directly addresses the 3-day expedited authorization process question in C2d. We have highlighted the sections on pages 2, 4 and 5 in Policy 719 that specifically

address the 3-day expedited authorization process. This policy is specifically focused on authorization of services for foster youth, KinGAP, adoptees and non-minor dependents placed outside the county of origin.

3. Policies 706, 707 and 719 are included in Appendix G as evidence to demonstrate that Contra Costa County is complying with regulatory requirements as indicated in DMH Information Notice: 09-06 and W& I Code Sections 5777.7, 11376 and 16125 regarding SARs for non-hospital SMHS.

4. The designated SAR Points of Contact are responsible for verifying medical necessity, authorizing or obtaining authorization, and processing the SARs. They will comply with county policies and the State's regulatory guidelines ensuring the 3-business-day expedited authorization requirements. The SAR Point of Contact will be trained on the updated polices and will be monitored. Any SARs missing vital information and requiring additional review or consultation for final approval will be documented and finalized within the maximum of the 14-day timeline whichever is sooner.

See Appendix G for supporting documentation

PROTOCOL REQUIREMENTS

C4. Regarding out-of-plan services to beneficiaries placed out of county:

C4a. Does the MHP provide out-of-plan services to beneficiaries placed out of county?

C4b. Does the MHP ensure that it complies with the timelines for processing or submitting authorization requests for children in a foster care, AAP, or KinGAP aid code living outside his or her county of origin?

C4c. Does the MHP ensure access for foster care children outside its county of adjudication and ensure it complies with the use of standardized contract, authorization procedure, documentation standards and forms issued by DHCS, unless exempted?

FINDINGS

The MHP did not furnish evidence it complies with the timelines for processing or submitting authorization requests for children in foster care, AAP, or KinGAP aid code living outside his or her county of origin. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 719 Authorization of Services to Foster Care, KinGAP, AAP children non-minor dependents placed outside of county of origin; and SARs log for children in foster care, AAP, or KinGAP aid code living outside his/her county of origin. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements.

Specifically, the log did not contain the dates the authorizations were made, making it impossible to track authorization timelines. The MHP stated that they strive to meet a 3 business day authorization timeline. Protocol question C4b is deemed OOC.

8. CONTRA COSTA PLAN OF CORRECTION C4b

1. Policy 719 is currently being revised and will be renamed as Service Authorization Requests for Foster Youth, Aid to Adoptive Parents, KinGAP and Non-Minor Dependent Beneficiaries Placed Outside of County of Origin. A copy of the current draft is included to show proof of effort to reflect changes in SAR usage due to AB 1299 mandates while still including the 3-day expedited authorization requirement. We have done this to ensure compliance with new regulatory mandates regarding the use of SARs for foster youth, AAP and KinGAP aid code beneficiaries residing out-of-county.

2. To specifically address the concerns with the County's SAR tracking log that was deemed out of compliance, a column was added to the log on April 1, 2018, to capture the date the SAR is received. We will be able to verify if the 3-day expedited time line is being met. This will be checked against the date for decision to authorize or deny the SAR.

3. Included in Appendix H is a SAR log showing that the column for Date SAR Received has been added. It now shows the date the SAR was received, date response sent by fax, authorization start date, and authorization end date and name of county contact.

4. The SAR point of contact line staff will be trained by the Children's Program Manager has set a workflow process in place to ensure the Date SAR Received shall be entered on the same day the SAR was received or within 3 business days of receiving it for accurate tracking and verifying the SAR is authorized and processed. The actual Date SAR Received will be the date entered on the SAR log.

5. The drafted / updated Policy 719 will now contain a small procedural section to ensure compliance with the timelines for the SAR Points of Contact processing or submitting authorization requests for children with the AAP or KinGAP aid codes living outside the county of origin. It will also address foster youth SAR usage exceptions and AB 1299.

6. The SAR point of contact and any additional clerical staff members who assist in SAR monitoring will be trained on the process and the policy. In addition, the SAR Point of Contact will send a monthly report to the Children's Program Manager responsible for SAR monitoring, the Child/Adolescent Program Chief and the Deputy Director for additional monitoring and compliance assurance.

See Appendix H for supporting documentation

PROTOCOL REQUIREMENTS

C6d. NOA-D: Is the MHP providing a written NOA-D to the beneficiary when the MHP fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals?

FINDING

The MHP did not furnish evidence it provides a written NOA-D to the beneficiary when the MHP fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 815 Notices of Action. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP stated they have not issued any NOA-Ds over the span of the triennial review period. However, upon reviewing the grievance and appeals logs it was noted that two (2) grievances were not resolved within 60 days, and five (5) appeals initiated in 2014 and 2015 did not show a decision date where the appeal would be closed. There was no evidence that a NOA-0 had been issued for these seven (7) items. Protocol question C6d is deemed OOC.

9. CONTRA COSTA PLAN OF CORRECTION C6d

In order to address the findings that MHP was deemed out of compliance with the requirement of issuing NOA-D's when there is a failure to resolve grievances, appeals or expedited appeals within the standard timeframe policy 815 Notice of Action was revised. This policy is now titled Policy 815, Notice of Adverse Benefit Determination, in order to accurately reflect the updated policy content, and the NOA-D is now referred to as the NOABD – Grievance and Appeal Timely Resolution notice. Policy 815 now specifically states the timeframes in which the notice shall be sent. Please see attached Policy 815 and refer to the highlighted sections. The MHP is also providing as evidence of compliance, a sample NOABD – Grievance and Appeal Timely Resolution Notice on the DHCS template, included in Appendix I. The Quality Management Program Coordinator provided training to staff member responsible for issuing the NOABD – Grievance and Appeal Timely Resolution Notice. This training included providing and reviewing in detail the MHSUDS Information Notice No. 18-010E and enclosures including the timeframe for standard and expedited resolutions and the NOABD that is issued if MHP fails to find and report a resolution within the required timeframes. Please see attached MHSUDS Information Notice No. 18-010E, which has been signed and dated by staff and training manager on the date of training. A log to track issuance of NOABD – Grievance and Appeal Timely Resolution Notices will be maintained as referenced in Policy 815. Please see the attached Grievance and Appeal Timely Resolution log.

See Appendix I for supporting documentation

PROTOCOL REQUIREMENTS

C6e. NOA-E: Is the MHP providing a written NOA-E to the beneficiary when the MHP fails to provide a service in a timely manner, as determined by the Contractor (MHP)?

FINDING

The MHP did not furnish evidence it provides a written NOA-E to the beneficiary when the MHP fails to provide a service in a timely manner. OHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 815 Notices of Action; NOA-E template letter; the Contra Costa Mental Health Services Timeliness Self - Assessment for FY 14-15 Site Reviews; and the Self-Assessment of Timely Access for FY 14-15 Site Reviews. Also, the MHP stated that they did not issue any NOA-Es during the triennial period. However, it was determined the documentation lacked sufficient evidence of Compliance with regulatory and/or contractual requirements. Specifically, evidence presented demonstrated that many beneficiaries did not receive services within the MHPs timeliness standard of 15 days. For example, the Timely Access data shows that the 15-day goal was met 65.4% of the time in FY 14-15, and 89.5% of the time in FY 15-16. Also, with a new method to track first appointment offered in 2016, the MHP reported that 92% of beneficiaries met the timeliness standard. The remaining 34.6%, 10.5%, and 8°/of the beneficiaries who did not meet the timeliness standard should have been issued a NOA-E. Protocol question C6e is deemed OOC.

10. CONTRA COSTA PLAN OF CORRECTION C6e

In order to address the findings that the MHP was deemed out of compliance with the requirement of issuing NOA-E's when the MHP fails to provide access to services in accordance with its own timeliness standards, Policy 815, Notice of Action, was revised. This policy is now titled Policy 815, Notice of Adverse Benefit Determination, in order to accurately reflect the updated policy content and the NOA-E is now referred to as the NOABD – Timely Access Notice. This policy now specifies the procedure of maintaining a log and the forwarding of that log and NOABD Timely Access notices to Behavioral Health Administration by the 10th of each month for tracking purposes. Please see attached Policy 815 and refer to highlighted sections as well as the attached NOABD Timely Access log. In addition, the MHP is providing as evidence of compliance, a sample NOABD – Timely Access to Services notice. Please see attached NOABD – Timely Access to Services notice sample. Within the next 90 days, MHP will provide training to staff overseeing issuance of NOABD – Timely Access Notices, and provide those staff the NOABD Timely Access log and NOABD Timely Access template to begin issuance of NOABD Timely Access notices. MHP will retain sign-in sheets and training agenda and will furnish to DHCS upon request.

See Appendix J for supporting documentation

SECTION D: BENEFICIARY PROTECTION

PROTOCOL REQUIREMENTS

D2. The MHP is required to maintain a grievance, appeal, and expedited appeal log(s) that records the grievances, appeals, and expedited appeals within one working day of the date of receipt of the grievance, appeal, or expedited appeal.

D2a. The log must include:

1) The name or identifier of the beneficiary.
2) The date of receipt of the grievance, appeal, and expedited appeal.
3) The nature of the problem.

FINDINGS

The MHP did not furnish evidence it maintains an appeal log that records the appeals. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 804.1 Outpatient Mental Health Consumer Appeal and Expedited Appeal Procedures; and the Appeal Log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the log did not include the required field 'nature of the problem'. Protocol question D2a3 is deemed OOC.

11. CONTRA COSTA PLAN OF CORRECTION D2a3

In order to demonstrate compliance in this area, the appeal policy was revised in order to reflect all required fields for the appeal and expedited appeal log. Please see Appendix K, Policy 804.1, Medi-Cal Beneficiary Appeals and Expedited Appeals, and refer to the highlighted section. In addition, in order to provide evidence of compliance in the short term, MHP has established updated appeal and expedited appeal logs to meet this requirement. Please see Appendix K for the Appeal - Expedited Appeal log and refer to the highlighted column, “Nature of the Problem.”

See Appendix K for supporting documentation

PROTOCOL REQUIREMENTS

D2b. Does the MHP's log match data reported in the Annual Beneficiary Grievance and Appeal report submitted to DHCS?

FINDING

The MHP's grievance and appeal logs did not match data reported to DHCS in the Annual Beneficiary Grievance and Appeal Report for fiscal years 2014-15 and 2015-16. Specifically, The MHPs log reported 15 appeals in 2014-15, and 1 appeal in 2015-16. The MHP reported no appeals to DHCS during those two fiscal years. Protocol question D2b is deemed OOC.

12. CONTRA COSTA PLAN OF CORRECTION D2b

In order to ensure accuracy and accountability in this area, the Quality Improvement Coordinator or designated staff will report on grievances and appeals quarterly at Quality Management meeting as referenced in the now-updated Policy 804.1, Medi-Cal Beneficiary Appeals and Expedited Appeals. Please see Appendix L attached, Policy 804.1 and refer to the highlighted sections. This report will be presented by the Quality Improvement Coordinator or designated staff and will include the number of appeals, expedited appeals and grievances for each quarter. At the end of the year, these reports will also be reconciled with the Annual Beneficiary Grievance and Appeal Report and brought to the end of year quarterly report to the established Quality Management meeting. At this meeting any issues will be noted and addressed. The Quality Management Program Coordinator signs off on the minutes at this meeting and will sign off once reconciled. Please see the attached Quality Management Meeting Minutes sample.

See Appendix L for supporting documentation

PROTOCOL REQUIREMENTS

D3. Regarding established timeframes for grievances, appeals, and expedited appeals:

D3a.

1) Does the MHP ensure that grievances are resolved within established timeframes?

2) Does the MHP ensure that appeals are resolved within established timeframes?

3) Does the MHP ensure that expedited appeals are resolved within established timeframes?

D3b. Does the MHP ensure required notice(s) of an extension are given to beneficiaries?

FINDINGS

The MHP did not furnish evidence it ensures grievances, appeals, and expedited appeals are resolved within established timeframes and/or required notice(s) of an extension are given to beneficiaries. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 804.1 Outpatient Mental Health Consumer Appeal and Expedited Appeal Procedures, Grievance Log; and Appeal Log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, two grievances were not resolved within the 60-day requirement, and two (2) appeals from

2014 and 2015 were still showing as open on the log. There was no evidence that an extension was provided to the beneficiaries.

In addition, DHCS inspected a sample of ten (10) grievances to verify compliance with regulatory requirements. NOTE: Besides the log, there was no documentation available on any of the appeals. Those appeals were coordinated by a staff who is no longer with the MHP.

Protocol questions D3a1 and. 03a2 are deemed in partial compliance. Protocol question D3b is deemed OOC.

13 - 15. CONTRA COSTA PLAN OF CORRECTION RESPONSE D3a1 & D3a2 & D3b
The MHP has increased staffing in the Quality Improvement Unit in order to provide increased monitoring and tracking of grievances, appeals and expedited appeals. In addition to the Quality Improvement Coordinator, the Mental Health Clinical Specialist and the Quality Management Program Coordinator have access to the grievance, appeal and expedited appeal logs. This more comprehensive access plan and information sharing has increased needed checks and balances so that MHP can assure compliance in this area. Additionally, the Quality Improvement Coordinator and/or the Mental Health Clinical Specialist will report monthly at the established Quality Management meeting on all outstanding grievances, appeals and expedited appeals. Any issues raised at this meeting will be documented and addressed. The Quality Management Program Coordinator signs off on all minutes to assure that issues that arise are addressed. This new process will take place starting at the next scheduled Quality Management meeting on May 23, 2018. Policy 804.1, Medi-Cal Beneficiary Appeals and Expedited Appeals, was also revised to reflect this requirement. Please see Appendix M, QM Meeting Minutes Sample and Policy 804.1, Medi-Cal Beneficiary Appeals and Expedited Appeals, and refer to the highlighted sections. In order to address the note by DHCS that the appeals lacked documentation apart from the appeal log, Policy 804.1 was revised to include the required notification documentation (Notification of Appeal Resolution). All NAR forms will be retained by the MHP for audit and reporting purposes. Again refer to Appendix M, Policy 804.1 and refer to the highlighted sections.

See Appendix M for supporting documentation

PROTOCOL REQUIREMENTS

D4. Regarding notification to beneficiaries:

D4a. Does the MHP provide written acknowledgement of each grievance to the beneficiary in writing?

2) Is the MHP notifying beneficiaries, or their representatives, of the grievance disposition, and is this being documented?

D4b. 1) Does the MHP provide written acknowledgement of each to the beneficiary in writing?

Is the MHP notifying beneficiaries, or their representatives, of the appeal disposition, and is this being documented?

D4c. Does the MHP provide written acknowledgement of each expedited appeal to the beneficiary in writing?

Is the M.HP notifying beneficiaries, or their representatives, of the expedited appeal disposition, and is this being documented?

FINDINGS

The MHP did not furnish evidence it provides written acknowledgement of each expedited appeal to beneficiaries. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 804.1, Outpatient Mental Health Consumer Appeal and Expedited Appeal Procedures. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the policy did not include language that a written acknowledgement would be sent for each expedited appeal received.

Besides the appeal log, the MHP had no appeal or expedited appeal documentation in either hard copy or electronic format available for review. An employee who no longer works for the MHP was responsible for the processing for grievances, appeals, and expedited appeals.

	#REVIEWED	ACKNOWLEDGEMENT		DISPOSITION		COMPLIANCE PERCENTAGE
		#IN	#OOC	#IN	#OOC	
Grievances	10	10	0	10	0	100%
Appeals.	N/A	N/A	N/A	N/A	N/A	N/A
Expedited Appeals	N/A	N/A	N/A	N/A	N/A	N/A

Protocol question D4c1 is deemed OOC.

16. CONTRA COSTA PLAN OF CORRECTION D4c1

In order to provide evidence of compliance that MHP sends acknowledgement letters for receipt of appeals and expedited appeals, Policy 804.1 was revised and renamed Medi-Cal Beneficiary Appeals and Expedited Appeals. It now indicates that the MHP sends acknowledgement letters for expedited appeals and that this acknowledgement letter shall be documented in the Appeals log. Also included as evidence that MHP provides acknowledgement letters with all required elements are sample letters of an acknowledgement letter for an appeal, a “not qualifying for expedited appeal” acknowledgement letter, and an acknowledgement letter for an expedited appeal. Please see Appendix N, acknowledgement letters, Policy 804.1, and Appeals – Expedited Appeals log.

See Appendix N for supporting documentation

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SECTION G: PROVIDER RELATIONS

PROTOCOL REQUIREMENTS

G3. Regarding the MHP's ongoing monitoring of county-owned and operated and contracted organizational providers:

G3a. Does the MHP have an ongoing monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified as per title 9 regulations?

G3b. Is there evidence the MHP's monitoring system is effective?

FINDINGS

The MHP did not furnish evidence it has an ongoing and effective monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified per title 9 regulations. DHCS reviewed the following documentation as evidence of compliance: the DHCS-generated Overdue Provider Report, data pulled 4/3/2017. Specifically, four (4) out of the 100 Medi-Cal active providers were overdue on their re-certifications, 4% were out of compliance.

The table below summarizes the report findings:

TOTAL ACTIVE PROVIDERS (per OPS)	NUMBER OF OVERDUE PROVIDERS (at the time of the Review)	COMPLIANCE PERCENTAGE
100	4	96%

Protocol question G3b is deemed in partial compliance.

17. CONTRA COSTA PLAN OF CORRECTION G3b

The MHP has a history of full compliance with the requirements of certification of its providers. The Provider Services Unit maintains a detailed log of the certification dates and does contact providers for recertification well ahead of time. The Provider Services Unit has increased the time of notification from 30 days to 60 days in advance of the recertification due date. Reflected in the audit review of certifications were two entities

for which Contra Costa relies on the host county's certification. The delays in receiving the appropriate recertification documents from the host county had caused delays in Contra Costa's compliance with the certification requirements of its providers. If we are unable to obtain those documents in the future, the CCBHS Provider Services Unit will perform their own site certification prior to the due date.

See Appendix O for supporting documentation

SECTION H: PROGRAM INTEGRITY **PROTOCOL REQUIREMENTS**

H4. Regarding disclosures of ownership, control and relationship information:

H4a.
Does the MHP ensure that it collects the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents, as required in CFR, title 42, sections 455.101 and 455.104 and in the MHP Contract, Program Integrity Requirements?

FINDING
The MHP did not furnish evidence it collects the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents as required in regulations and the MHP Contract. The MHP stated that they are not currently collecting ownership disclosures. Protocol question H4a is deemed OOC.

18. CONTRA COSTA PLAN OF CORRECTION H4a

For County employees, and as required by Contra Costa Health Services Personnel Department, specified "Designated Positions", primarily management positions, are required to submit the IRS Form 700, Statement of Economic Interests, by April 1 of each year. Appendix P includes the most recent 2017 email request for County employees to submit their forms, as well as the current list of Designated Positions. Health Services Personnel will continue to maintain these forms on file for the MHP, and upon DHCS request, completed forms will be furnished for review.

For contracted providers, the MHP is embedding language within FY 18/19 contracts to include the requirement to disclose Ownership and Control information. In immediate response to our DHCS Triennial site visit in April 2017, the Behavioral Health Operations Unit began to work closely with County's Health Services Contracts and Grants, Finance and other stakeholder groups to discuss implementation of the new requirements and to discuss potential implications and impacts. Contracted providers have been informed of the impending changes and requirements to their contracts and have been included in the process of reviewing draft language since January 2018.

Please see below for the newly revised language:

8. **Conflicts of Interest:** Contractor presently has no interest, including but not limited to other projects or independent Agreements, and shall not acquire any such interest, direct or indirect, which would conflict in any manner or degree with the performance of services required to be performed under this Agreement. The Contractor shall not employ any person having any such interest in the performance of this Agreement. Contractor shall not hire County's employees to perform any portion of the work or services provided for herein including secretarial, clerical and similar incidental services except upon the written approval of County. Without such written approval, performance of services under this Agreement by associates or employees of County shall not relieve Contractor from any responsibility under this Agreement.

8.1 California Political Reform Act and Government Code Section 1090 Et Seq: Contractor acknowledges that the California Political Reform Act ("Act"), Government Code section 81000 et seq., provides that Contractors hired by a public agency, such as County, may be deemed to be a "public official" subject to the Act if the Contractor advises the agency on decisions or actions to be taken by the agency. The Act requires such public officials to disqualify themselves from participating in any way in such decisions if they have any one of several specified "conflicts of interest" relating to the decision. To the extent the Act applies to Contractor, Contractor shall abide by the Act. In addition, Contractor acknowledges and shall abide by the conflict of interest restrictions imposed on public officials by Government Code section 1090 et seq.

8.2 Ownership and Control**:** Through its contract with the State, the County is required that each MHP Contractor provide written disclosure of any prohibited affiliation under §438.610; and provide written disclosures of information on ownership and control required under §455.104 of the Code of Federal Regulations (42 CFR). Contractor shall inform the County of all the Contractor's interests, if any, which are or which the Contractor believes to be incompatible with any interests of the County.

8.2.1 The Contractor shall not, under circumstances that might reasonably be interpreted as an attempt to influence the recipient in the conduct of his duties, accept any gratuity or special favor from individuals or organizations with whom the Contractor is doing business or proposing to do business, in accomplishing the work under this Agreement.

8.2.2 Contractor shall not use for personal gain or make other improper use of confidential information, which is acquired in connection with his employment. In this connection, the term "confidential information" includes, but is not limited to, unpublished information relating to

technological and scientific development; medical, personnel, or security records of the individuals; anticipated materials requirements or pricing actions; and knowledge of selections of Contractors or subcontractors in advance of official announcement.

8.2.3 The Contractor, or employees thereof, shall not offer directly or indirectly gifts, gratuity, favors, entertainment, or other items of monetary value to an employee or official of the County.

8.2.4 Referrals: Contractor further covenants that no referrals of clients through Contractor's intake or referral process shall be made to the private practice of any person(s) employed by the Contractor.

In order to address Section 8.2 of the MHP contract, contracted providers will be required to submit an Economic Interest 700 Form on an annual basis to disclose any information on ownership and control for individual employees and/or Board Members. Furthermore, a copy of an executed FY 18/19 contract can be provided to DHCS upon request in order to provide evidence of the newly implemented requirement effective July 1, 2018.

See Appendix P for supporting documentation

Chart Review Findings Report
Contra Costa County Mental Health Plan

Plan of Correction 1c-1:

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBOs) and County Owned and Operated Clinics. This year, the MHP has increased the post-service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

Policy 709, page 16, Sections K 4a and 4b, specifically states that all "clinical service progress notes must include the following information:

a. Description of current situation (Reason for contact, consumer concerns, status update, behavioral acuity, current stressors, needs, mental health goals must be addressed in plan, etc.).

b. Focus of activity (Interventions, interventions that address the mental health impairment that have been identified in the assessment and plan, response to interventions, purpose of group, benefit to the client, and/or reason for multiple group facilitators, etc.).

Per Policy 709, page 7 Section D 6a and 6b, the partnership plan must adhere to the

following:

a. Goals must include “specific, observable, and/or quantifiable” goals/treatment objectives to the beneficiary’s mental health needs and functional impairments as a result of the mental health diagnosis.

b. Proposed strategies should be identified to meet desired mental health treatment goal(s) on the plan.

In the 2017 Clinical Documentation Guide, Page 7, Section 2.1, service providers are trained to document in each clinical progress note that the service was “medically necessary”.

> “Progress notes should clearly indicate the type of service provided and how the service was medically necessary to address an identified area of impairment, and the progress (or lack of progress) in treatment.
>
> Clinicians should document how the intervention provided relates to the clinical goals written in the treatment plan, addresses behavioral issues and/or link to the mental health condition. Remember a “medically necessary service” is on which attempts to improve functional impairments impacted by a symptom of the client’s mental health diagnosis.”

In the 2017 Clinical Documentation Guide, Page 12, Section 3.3, service providers are trained to document in each clinical progress note that the service was “medically necessary”.

> “The assessment is critical for establishing the diagnostic impression and identifying functional impairments. The Partnership Plan takes the information gathered during the assessment process and directs the focus of services. The Partnership Plan also links the interventions to the impairments. The progress notes describe the specific service provided and establish that the service is meant to address the impairments in keeping with the Partnership Plan.

See Appendix CR- A for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 7/Section 2.1 “General Principles of Documentation” #8
- 2017 Clinical Documentation Guide, Page 12/Section 3.3 “Medical Necessity”
- Documentation Training Fliers

Contra Costa Plan of Correction 1c-2:

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

Policy 709, page 16, Section K 4a and 4b, specifically states that all "clinical service progress notes must include the following information:

a. Description of current situation (Reason for contact, consumer concerns, status update, behavioral acuity, current stressors, needs, mental health goals must be addressed in plan, etc.).

b. Focus of activity (Interventions, interventions that address the mental health impairment that have been identified in the assessment and plan, response to interventions, purpose of group, benefit to the client, and/or reason for multiple group facilitators, etc.).

Per Policy 709, page 7 Section D 6a and 6b, the partnership plan must adhere to the following:

a. Goals must include "specific, observable, and/or quantifiable" goals/treatment objectives to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.

b. Proposed strategies should be identified to meet desired mental health treatment goal(s) on the plan.

In the 2017 Clinical Documentation Guide, page 7, Section 2.1, service providers are trained to document in each clinical progress note that the service was "medically necessary".

> "Progress notes should clearly indicate the type of service provided and how the service was medically necessary to address an identified area of impairment, and the progress (or lack of progress) in treatment.
>
> Clinicians should document how the intervention provided relates to the clinical goals written in the treatment plan, addresses behavioral issues and/or link to the mental health condition. Remember a "medically necessary service" is on which attempts to improve functional impairments impacted by a symptom of the client's mental health diagnosis."

In the 2017 Clinical Documentation Guide, Page 12, Section 3.3, service providers are trained to document in each clinical progress note that the service was "medically necessary".

> "The assessment is critical for establishing the diagnostic impression and identifying functional impairments. The Partnership Plan takes the information gathered during the assessment process and directs the focus of services. The Partnership Plan also links the interventions to the impairments. The progress notes describe the specific service provided and establish that the service is meant to address the impairments in keeping with the Partnership Plan.

See Appendix CR- B for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 7/Section 2.1 "General Principals of Documentation" #8
- 2017 Clinical Documentation Guide, Page 12/Section 3.3 "Medical Necessity"
- Documentation Training Fliers

Contra Costa Plan of Correction 2a:

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

Per Policy 709, page 2, the assessment must adhere to the following timeframes frequency:

> "Service Providers are required to produce timely, accurate and complete documentation of client's history and current treatment. MHP County Owned and Operated Clinics and CBOs shall use county-approved forms for documentation unless otherwise approved by MHP."

Per Policy 709, page 6, Section C3, the assessment must adhere to the following timeframes frequency:

> "The Annual Assessment must be completed before the current authorization period expires. MHP requires that the annual assessment be conducted/completed within the last month of the authorization. (Refer to Policy 706 for timeframes)."

Per Policy 706, Page 8, Section D1,

> "Service Authorization shall be obtained prior to the expiration of the authorization period listed on the Service Authorization Form or the BHS Service Authorization Form. MHP requires that the annual assessment be conducted/completed within the last month of the authorization. "

Utilization Review uses Report MHS 192 Coordinated Services Utilization Control (UC) to inform staff of impending authorization due dates.

> Clients appearing on the MHS 192 report if their current UC Authorization is "initial", or the current UC Authorization is expiring, or their allocation of visits are expiring, or any combination of these. Then clients will continue to appear on this report until a new UC Authorization is entered.

See Appendix CR- C for supporting documentation.

- Policy 709
- Policy 706
- Documentation Training Fliers
- Sample MHS 192 report

Contra Costa Plan of Correction 2b:

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

Per Policy 709, page 2, A, the assessment must contain all of the required elements:

A. **Assessment**

1. Clients seeking Mental Health Services will be assessed by a licensed/licensed eligible or waivered clinician to establish need for services, appropriate level of care and that medical/service necessity criteria established in Title 9 are met.

2. Clinical Assessments should have the following elements:

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

   b. Relevant conditions and psychosocial factors: Factors affecting the beneficiary's physical 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 dates, providers, therapeutic modalities (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 consulting reports. Cultural context should be taken into consideration when doing client assessments.

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, complementary and alternative mediations (CAM) over-the-counter drugs, and illicit drugs.

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

h. Risks: Situations that present a risk to beneficiary and/or others, including past or current trauma.

i. Mental Status Examination (must be completed by a licensed/licensed eligible or waivered clinician).

j. Complete Diagnosis: Effective April 1, 2017 MHP will require a DSM 5 diagnosis, which includes the DSM 5 code,

diagnosis name/narrative, and corresponding ICD-10 code. The diagnosis must be consistent with presenting problems, history, mental status exam and/or other clinical data.

i) The primary diagnosis shall fall into one of the included diagnosis categories as established in Title 9 and must be completed by a licensed/licensed eligible or waivered clinician.

ii) In order to obtain service authorization, providers are required to use most current CCBH Outpatient Crosswalk when determining medical necessity. DSM 5 code, diagnosis name/narrative, and corresponding ICD-10 code must match crosswalk to be considered valid.

k. For children and adolescents, effective October 1, 2018, Child and Adolescent Needs and Strengths (CANS) Core 50 Elements will be incorporated within the current Initial Assessment. CANS Update form is currently in the design process. (Will provided the forms if needed once completed)

i) CANS Update Form is required every 6 month and at discharge

l. The plan for continued care should include the following:

m. The date of service and date of completion (signature date).

n. The signature of the person providing the service (or electronic equivalent), the signer's professional degree and licensure or job title (must be completed by a licensed/licensed eligible or waivered clinician).

Per Policy 709, page 18, Section O 4, 4a, 4ai, the assessment must contain all required elements and completely fully:

"All MHP forms must be completed fully.

a. The Service Provider shall fill in all lines and spaces on a form.

i) If the statement does not fit a certain situation or an answer cannot be obtained, the Service Provider shall indicate with N/A, a hyphen ("-") or "UTO" (unable to obtain) or another similar phrase to indicate that the question was asked and not answered."

In the 2017 Clinical Documentation Guide, page 11, Section 3.2 service providers are trained complete the assessment fully so that all required elements are assessed.

The assessment must contain:

a. Presenting problem(s)
b. Relevant conditions affecting physical and mental health status (e.g. living situation, daily activities, and social support, cultural and linguistic factors and history of trauma or exposure to trauma);
c. Mental health history, (previous treatments dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information, lab tests, and consultation reports); and
d. Medical History including: physical health conditions reported by the client are prominently identified and updated; name and contact information for primary care physician; allergies and adverse reactions, or lack of allergies/sensitivities; and
e. Medications, dosages, dates of initial prescription and refills, and informed consent(s); and
f. Substance Expose and Use Past and present use of tobacco, alcohol, and caffeine, as well as, illicit, prescribed, and over-the-counter drugs; and
g. Mental Status Examination (included on the psychosocial Assessment); and
h. Client and/or family strengths; and
i. Risks and barriers relevant to achieving client plan goals, including past or current trauma, psychosocial factors which may present a risk in decompensation and/or escalation of the client's condition (e.g. history of danger to self, danger to others, previous hospitalizations, suicide attempts, lack of family, prior arrests, prior drug use, history of self-harm (cutting, or assaultive behavior), physical impairments which makes the client vulnerable to others (e.g. wheelchair bound, visual impairment, deaf)
j. Effective April 1, 2017, an included DSM5 diagnosis and corresponding ICD-10 code consistent with the presenting problems, history, mental status examination and/or other clinical data, and,
k. For children and adolescents, effective October 1, 2018, Child and Adolescent Needs and Strengths (CANS) Core 50 Elements will be incorporated within the current Initial Assessment. CANS Update form is currently in the design process. (Will provided the forms if needed once completed)
l. For children and adolescents, prenatal events, and complete developmental history, and,
m. Additional clarifying formulation information, as needed.

The Clinician filling out the Assessment must ensure that all sections are

completely and accurately filled out. Do not leave any sections blank as these may cause a mandated section to remain unassessed and may lead to disallowances.

See Appendix CR- D for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 11/Section 3.2 “Assessment”.
- Documentation Training Fliers

Contra Costa Plan of Correction 2c:

The MHP’s Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO’s) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

Per Policy 709, page 18, Section O 2, MHP signature requirements are as follows:

> "Signatures shall include at a minimum service provider’s first initial, last name followed by license number or designation.”

In the 2017 Clinical Documentation Guide, page 9, Section 2.2 service providers are trained so that the signature requirements are as follows.

> “Clinical staff signature is a required part of most clinical documents. During the audit period the MHP did not have an EHR within the county owned and operated clinics, therefore, requires “wet signatures” on all Assessments, Annual Updates, Partnership Plan for Wellness, and Progress Notes. At minimum the signatures must include first initial of first name, full last name, and date.
>
> Each signature must include licensure and/or designation (e.g. ASW, MD, LMFT, MHRS, DMHW, PhD waivered, etc.).”

See Appendix CR- E for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 9/Section 2.2 “Signatures”.
- Documentation Training Fliers

Contra Costa Plan of Correction 3B:

The MHP’s pharmacist currently conducts Medication Monitoring/Peer Review audits on Psychiatrists working within MHP County Owned and Operated Clinics. Audit occurs routinely on at least a quarterly basis. MD/NP’s and the Medical Directors are notified

regarding findings and deficiencies from Medication Monitoring Review. Deficiencies are to be address within 12 weeks from receipt of notification. MHPis planning to modify ccLink progress note to include a medication consent validator/"reminder" box to ensure that the MD's/NP's have an valid updated/completed medication consent form which must be checked in order to finalize the psychiatric progress note.

In addition, MHPwill take proactive measures during level I (UR Authorization Committee) to ensure consents are complete. URC members, will "pend" authorization and return to MD for completion of consent if found to be incomplete at time of authorization.

Per Policy 709, Page 9, Section G, the elements of the medication consents are as follows:

> Medication Consent must be obtained for every new medication, an increase in dose from previous consent,
> a. Consent must be signed/dated by beneficiary/legal responsible party agreeing to each prescribed medication.
> b. Consent must include the following:
> i) Signature and Licensure/Date of Prescriber
> ii) Reason for taking medication
> iii) Reasonable for alternative treatments, if any
> iv) Type of medication
> v) Range of frequency
> vi) Dosage
> vii) Method of administration
> viii) Duration of taking the medication
> ix) Probably side effects
> x) Possible side effects, if taken for longer than three month
> c. Consents can be withdrawn at any time.
> d. Consents are valid for a period of two (2) years.

Per 2017 Clinical Documentation Guide, Page 47, Section 8.1, the Medication Consent requirements are listed as follows:

> A Medication Consent must be obtained for every new medication, an increase in dose from previous consent, or every 2 years thereafter. A note indicating discussion about medications and side effects doesn't replace the signed form. It is good practice to document a discussion about risks of not taking as prescribed, what side effects for client to be aware of, and other education about risks and benefits of taking or not taking the recommended medication. A parent or guardian must sign the consent for a minor for psychotropic medications. The MD/NP is also responsible for providing information to client about the specific medication, preferably in written form, at minimum verbally. This provision of information should be documented in the note.

Medication Consent Requirements:
a. Consent must be signed/dated by beneficiary agreeing to each prescribed medication.
b. Consent must include the following:
    i) Signature and Licensure/Date of Prescriber
    ii) Reason for taking medication
    iii) Reasonable for alternative treatments, if any
    iv) Type of medication
    v) Range of frequency
    vi) Dosage
    vii) Method of administration
    viii) Duration of taking the medication
    ix) Probable side effects
    x) Possible side effects, if taken for longer than three month
c. Consents can be withdrawn at any time

See Appendix CR- F for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 47/Section 8.1 “Medication Consents”.
- Medication Monitoring Committee Findings/Deficiency Sample Letter
- Medication Peer Review Protocol

Contra Costa Plan of Correction 4a-2

The MHP’s Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO’s) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

Will schedule Chart Review Audit on programs identified in finding report to ensure the all claims outside of the audit review period in which no client plan was in effect will be disallowed. Chart Review Audit will be conducted within next quarter.

Per Policy 709, page 7, Section F 5, the MHP requires that a service/treatment plan is completed on an annual basis:

> “Annually thereafter. In general, the annual requirement is determined by the established UR track and reflected on the Service Authorization Form. All service providers, including MDs seeing “Medication-only” beneficiaries must complete a Partnership Plan for Wellness or Psychiatric Treatment Plan within the last month of the authorization. (Refer to Policy and Procedure 706 for timeframes)”.

Per Policy 706, Page 8-9, Section D1, D2e and D3c which outlines timeframes in which the Plan must be completed.

> "Annual Reauthorization of Service for Initial and Additional Service Provider(s) (Existing Clients open for greater than 1 year):
>
> 1. Service Authorization shall be obtained prior to the expiration of the authorization period listed on the Service Authorization Form or the BHS Service Authorization Form. MHP requires that the annual assessment be conducted/completed within the last month of the authorization.
>
> 2. County Owned and Operated clinics shall complete and electronically file the following during the last month of the current authorization:
>
> e. BHS Partnership Plan/Partnership Plan for Wellness
> i) Must be completed in ccLink and printed to
> ii) Must be completed in ccLink and printed to
> a) Obtain required signatures or provide documentation as to why signatures were not obtained AND
> b) Documentation of client participation and agreement with plan as written.
>
> 3. CBOs shall complete and submit the following documentation during the last month of the current authorization to the Service Authorization Committee for review and
> c. Partnership Plan for Wellness (MHC021) or
> Partnership Plan for Wellness: Children (Physicians and RNs) (MHC110) or
> Partnership Plan for Wellness: Adult (Physicians and RNs) (MHC105)
> i. Must be completed with all required signatures or provide documentation as to why signatures were not obtained AND
> ii. Documentation of client participation and agreement with plan as written.

Per the 2017 Clinical Documentation Manual, Page 16, Section 4.1.2, service providers are trained to complete partnership plans within timeframes outlined below:

> "Partnership Plans must be reviewed and revised on an annual UR Track basis. For example, the "established UR Track period" is 10/1/2015 – 9/30/2016, the Annual Partnership Plan must be completed and signatures obtained by the last

day (end of the month) of the track, so that there is no break in service authorization. In this case the plan would need to be completed and brought for authorization by 9/30/2016.

If the UR Track expires and there is a lapse between the Annual Partnership Plan, then services provided during the lapse will be unauthorized. It is important to avoid lapses in renewals of annual Partnership Plans."

See Appendix CR- G for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 16/Section 4.1.2 "Timeliness of Partnership Plan"
- Documentation Training Flier

Contra Costa Plan of Correction 4b-1

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

The Policy 709, page 7, Section F 6a, specifically states the following:

> "Goals must include "specific, observable, and/or quantifiable" goals/treatment objectives to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis."

Per the 2017 Clinical Documentation Manual, Page 19, Section 4.4.4, service providers are trained to complete partnership plans so that goals are:

> "Clinical Treatment Goals must be "specific, observable or measurable" and stated in terms of the specific impairment identified in the Assessment, diagnosis and clinical formulation of Medical Necessity. They should be related to specific functioning areas such as living situation, activities of daily living, school, work, social support, legal issues, safety physical health, substance abuse and psychiatric symptoms."

See Appendix CR- H for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 19/Section 4.4.4 "Clinical Treatment Goals"
- Documentation Training Flier

Contra Costa Plan of Correction 4b-2

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

The Policy 709, page 7, Section F 6b, 6c, and 6d, specifically states the following:

a. Proposed strategies should be identified to meet desired mental health treatment goal(s) on the plan.

b. Goals must be time specific and have a proposed duration for the interventions listed.

c. Specify all the modalities that are needed to achieve the goal(s).

Per the 2017 Clinical Documentation Manual, Page 21, Section 4.4.5, service providers are trained to complete partnership plans so that strategies are:

> This section should define concrete strategies/actions that will be utilized to assist the client/family to meet the identified clinical treatment goals. In addition to the client's goals being developed in relationship to the diagnosis and/or impairments, it is essential that the strategies and timeframes outlined in the Partnership Plan reflect what the provider will do.
>
> There can be multiple strategies (different service types) for the same clinical treatment goal. Service types often include: medication services, group therapy, individual therapy, case management brokerage, and for the full service partnership clients, intensive case management. Each of the strategies needs to be specific and non-duplicative.

See Appendix CR- I for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 21, Section 4.4.5 "Strategies to Achieve Goals"
- Documentation Training Flier

Contra Costa Plan of Correction 4b-3

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and

Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

The Policy 709, page 7, Section D 6b, 6c, and 6d, specifically states the following:

d. Proposed strategies should be identified to meet desired mental health treatment goal(s) on the plan.

e. Goals must be time specific and have a proposed duration for the interventions listed.

f. Specify all the modalities that are needed to achieve the goal(s).

Per the 2017 Clinical Documentation Manual, Page 21, Section 4.4.5, service providers are trained to complete partnership plans so that strategies are:

> The Strategies section on the Partnership Plan defines the concrete strategies and techniques the service provider utilizes to facilitate the client's progress of the clinical treatment goals. These strategies are behavioral health interventions and address the impairment(s) identified in the Assessment. They are best stated using the five W's:
>
> → **Who:** Clinical discipline of practitioner (e.g. Therapist, case manager)
> → **What:** Modality/Service provided
> → **When:** Frequency/intensity/duration
> → **Where:** Location
> → **Why:** Purpose/intent/impact to address a specific mental health impairment
>
> This section should define concrete strategies/actions that will be utilized to assist the client/family to meet the identified clinical treatment goals. In addition to the client's goals being developed in relationship to the diagnosis and/or impairments, it is essential that the strategies and timeframes outlined in the Partnership Plan reflect what the provider will do.
>
> There can be multiple strategies (different service types) for the same clinical treatment goal. Service types often include: medication services, group therapy, individual therapy, case management brokerage, and for the full service partnership clients, intensive case management. Each of the strategies needs to be specific and non-duplicative.

See Appendix CR- J for supporting documentation.

- Policy 709

- 2017 Clinical Documentation Guide, Page 21, Section 4.4.5 “Strategies to Achieve Goals”
- Documentation Training Flier

Contra Costa Plan of Correction 4f

The MHP’s Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO’s) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

Per Policy 709, page 18, Section 8 2, MHP signature requirements are as follows:

> “Signatures shall include at a minimum service provider’s first initial, last name followed by license number or designation.”

Per Policy 709, page 8, Section F 7, MHP signature requirements for treatment plan author are as follows:

> “The Partnership Plan should document that the client/legal responsible party participated in development of the plan and agreed with the plan as written. In addition, MHP requires the plan contain the following signatures:
>
> c. Service Provider (person providing the service or person representing the team or program providing the service).”

Per the 2017 Clinical Documentation Manual, Page 9, Section 2.2, service providers are trained to affix signature as follows:

> Clinical staff signature is a required part of most clinical documents. During the audit period the MHP did not have an EHR within the county owned and operated clinics, therefore, requires “wet signatures” on all Assessments, Annual Updates, Partnership Plan for Wellness, and Progress Notes. At minimum the signatures must include first initial of first name, full last name, and date.
>
> Each signature must include licensure and/or designation (e.g. ASW, MD, LMFT, MHRS, DMHW, PhD waivered, etc.).

See Appendix CR- K for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 9, Section 2.2 “Signature”
- Documentation Training Flier

Contra Costa Plan of Correction 5a-1

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS. ccLink has been configured to allow the clinician to designate "late entry" notation if the progress note was not written within specified timeframe. The clinician must acknowledge that the progress note was written after five (5) business days and the "late entry" notation will automatically be added to body of progress note.

Per Policy 712, ensures that progress notes that are completed subsequent to the day the service was provided are accurately documented, labelled and billed. Progress note should be written on the same day that the service was provide and submitted for billing within 24 hours. If extenuating circumstances exist and documentation is not completed within five (5) business days of service, a "late entry" notation shall be documented.

Per the 2017 Clinical Documentation Manual, Page 28, Section 6.2, service providers are trained to complete progress notes within timeframes specified in Policy 709 and if not met must document "late entry" as per Policy 712:

> "All Progress Notes should be completed within 24 hours after the service was provided. MHP understands that extenuating circumstances may occur and thus, allows service providers up to five (5) business days from when the service was provided to complete the documentation. MHP's Policy (MHP Behavioral Health Division- Mental Health Plan, Policy 712, Documentation Requirements: Late Entry).
>
> When documentation does not occur within the five (5) business days, the service provider will note the date of service delivery in the billing section and indicate "late entry" on the progress note. Progress notes billed more than fifteen (15) days after service delivery are not billable and can be entered as non-billable notes.
>
> If documentation is not completed within five (5) business days, the service provider may NOT bill for documentation time.
>
> Any other documents related to a client (i.e. discharge summaries, labs, etc.) must also be filed in the client's clinical record as soon as practical. State regulations drive timeliness standards, which are based on the idea that documentation completed in timely fashion has greater accuracy and makes needed clinical information available for best care of the client.

> The intent of the five (5) business day documentation policy is to establish a trend of timely documentation. Timely documentation is not only about compliance with State expectations, but it is also about ensuring that clinically relevant and accurate information is available for the best care of the client."

See Appendix CR- L for supporting documentation.

- Policy 709
- Policy 712
- 2017 Clinical Documentation Guide, Page 28, Section 6.2 "Timeliness of Documentation of Service"
- Documentation Training Flier

Contra Costa Plan of Correction 5a-8

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

Per Policy 709, page 15, Section M 3l and page 18, O 2 MHP signature requirements are as follows:

> "Signatures shall include at a minimum service provider's first initial, last name followed by license number or designation."

Per Policy 709, page 16, Section M 3n, MHP requires signatures to be dated appropriately:

> "Date documentation completed/signed."

Per the 2017 Clinical Documentation Manual, Page 9, Section 2.2, service providers are trained to affix their signature as follows:

> Clinical staff signature is a required part of most clinical documents. During the audit period the MHP did not have an EHR within the county owned and operated clinics, therefore, requires "wet signatures" on all Assessments, Annual Updates, Partnership Plan for Wellness, and Progress Notes. At minimum the signatures must include first initial of first name, full last name, and date.
>
> Each signature must include licensure and/or designation (e.g. ASW, MD, LMFT, MHRS, DMHW, PhD waivered, etc.).

Per the 2017 Clinical Documentation Manual, Page 26, Section 6.0, service providers are trained to affix a signature date as follows:

> "Signature and date of the person providing the service, including professional degree, licensure or job title"

See Appendix CR- M for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 26, Section 6.0 "Progress Notes"
- Documentation Training Flier

Contra Costa Plan of Correction 5c

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

CCHBS has transition to electronic health record-ccLink. In order to ensure that only services that have been finalized in ccLink are entered into the claiming system, the billing clerks utilize ccLink report BHS4127, BH Outpatient Billing Notes Report. BHS 4127 is a report from ccLink which is used by county owned and operated clinics to reconcile services provided against PSP claiming reports. The use of this report decreases the risk that a claim is generated without proper documentation.

Per Policy 709, page 14, Section M 1, M1a, and M1b regarding frequency of progress notes:

1. After rendering a direct service to a client, Service Providers shall complete a Progress Note/Billing Form commensurate with the scope of practice. Direct services can be any mental health service (MHS), medication support service (MS), crisis intervention (CI), case management brokerage (CM), ICC, IHBS, TFC and TBS.
    a. The purpose of the Progress Note/Billing Form is to provide written documentation of a service provided to our clients.
    b. Billing may not be entered into the PSP system without a completed progress note.

Per Policy 709, page 14, Section M 2a, regarding frequency of progress notes:

2. Frequency of Progress Notes:

a. Progress notes are to be completed after each service contact for MHS, MS, CI, CM, ICC, IHBS, TFC and TBS.

Per the 2017 Clinical Documentation Manual, Page 28, Section 6.3, regarding frequency of progress notes:

> "While it has been noted that for every billing entry there must be a corresponding progress note, there are specific instances when documentation is not completed for every service contact."

See Appendix CR- N for supporting documentation.

- Policy 709
- Policy 710
- 2017 Clinical Documentation Guide, Page 28, Section 6.3 "Frequency of Documentation"
- Documentation Training Flier

Contra Costa Plan of Correction 5d

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

Per Policy 709, page 16, Section L 3l and page 18, Section O 2, MHP signature requirements are as follows:

> "Signatures shall include at a minimum service provider's first initial, last name followed by license number or designation."

Per Policy 709, page 16, Section M 3n, MHP requires signatures to be dated appropriately:

> "Date documentation completed/signed."

Per the 2017 Clinical Documentation Manual, Page 9, Section 2.2, service providers are trained to affix their signature as follows:

> "Clinical staff signature is a required part of most clinical documents. During the audit period the MHP did not have an EHR within the county owned and operated clinics, therefore, requires "wet signatures" on all Assessments, Annual Updates, Partnership Plan for Wellness, and Progress Notes. At minimum the

signatures must include first initial of first name, full last name, and date."

"Each signature must include licensure and/or designation (e.g. ASW, MD, LMFT, MHRS, DMHW, PhD waivered, etc.)."

Per the 2017 Clinical Documentation Manual, Page 26, Section 6.0, service providers are trained to affix a signature date as follows:

"Signature and date of the person providing the service, including professional degree, licensure or job title"

See Appendix CR- O for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 26, Section 6.0 "Progress Notes"
- Documentation Training Flier

Contra Costa Plan of Correction 6a

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS.

The MHP has made revisions to its informing materials to make this information more readily available to its beneficiaries. Specifically, the Contra Costa section of the Medi-Cal Guide book has been revised to clearly speak to this requirement. Additionally, MHP has created and required the posting of the Informing Material Poster in all its waiting rooms, both County and CBO. All providers are required to display this poster both in English and Spanish, the County's threshold language. The poster succinctly informs all Contra Costa beneficiaries of important information including that MHP's informing materials are available in alternative formats. The Informing Materials Policy (Policy 827) has been revised to reflect these new requirements.

Per Policy 709, page 16-17, Section M 3j and 3k, regarding linguistic accommodations while writing progress notes are as follows:

j. "If an interpreter is required for a monolingual client and is present during session, the Service Provider's documentation should contain the name of the interpreter.

k. If the translation service is provided in a language other than English, the Service Provider must indicate the language.

Per the 2017 Clinical Documentation Manual, Page 15, Section 4.1, service providers

are trained on how to document the use of interpreters to address linguistic needs as follows:

> "The plan must be individualized; strength based, and should address cultural and linguistic needs."

Per the 2017 Clinical Documentation Manual, Page 26, Section 3, service providers are trained on how to document the use of interpreters to address linguistic needs as follows:

> "If service is provided in a language other than English, document the language used. If an interpreter is used, include the name of the interpreter in the progress note."

See Appendix CR- P for supporting documentation.

- Policy 709
- 2017 Clinical Documentation Guide, Page 15, Section 4.1 "Partnership Plan for Wellness"
- 2017 Clinical Documentation Guide, Page 26, Section 3.0 "Progress Notes"
- Documentation Training Flier

Contra Costa Plan of Correction 7b

The MHP's Clinical Documentation Trainings are held at least one time per month with emphasis on documentation of medical necessity. The MHP currently conducts chart review audits on Community Based Organizations (CBO's) and County Owned and Operated Clinics. This year, the MHP has increased the post service documentation audit from 5% to 10% of all claimed services as recommended by DHCS. In addition, the UR Centralized Review Committee will request copies of the "attendance" sheet so that we can accurately audit attendance against claims. The MHP will revise Policy 709 to include the requirement for Day Treatment programs to maintain a "sign-in" sheet which accurately documents the length of time spent in the program daily.

Per Policy 709, page 18, Section M 8, regarding documentation of no shows and cancellations are as follows:

> "All No-Shows and cancellations must be entered in the PSP system and noted in the chart."

See Appendix CR- Q for supporting documentation.

- Policy 707
- Policy 709
- Policy 710

- Documentation Training Flier