Consolidated Specialty Mental Health Services
Fiscal Year 2016-2017
Ventura Mental Health Plan Review
March 27-30, 2017
Items Out of Compliance with Plan of Correction

SECTION B: ACCESS

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?

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

•CFR, title 42, section 438.406 (a)(1)

• DMH Information Notice No. 10-02, Enclosure, Page 21, and DMH Information Notice No. 10-17, Enclosure, Page 16

• MHP Contract. Exhibit A, Attachment I

FINDINGS:

In addition to conducting the eight (8) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Accessing Specialty Mental Health Services (P&P CT-13) (1/2011); VCBH Crisis Team Telephone Triage; 24/7 Crisis Services Program Description; Draft Use of Interpretation (CA-48) (4/2014); 24/7 Test Call Quarterly Update Report form (2); Accessing Mental Health Services Flyer in English and Spanish (P&P CA-53); and Test Call Survey Reports. However, it was determined the test call results lacked sufficient evidence of compliance with regulatory and/or contractual requirements regarding the 24/7 line provision of information on how to access SMHS and how a beneficiary may file a grievance with the MHP. Protocol question B9a2 is deemed in partial compliance and B9a4 is deemed OOC.

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PLAN OF CORRECTION:

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a statewide, toll-free number that provides information on how to access SMHS and how to use the beneficiary problem resolution and fair hearing processes.

VCBH Plan of Correction:

1. Reviewed and clarified process for crisis staff to inform callers about how to access Specialty Mental Health Services.
2. Reviewed and clarified process for crisis staff to inform callers about how to access Grievance procedures.
3. Reviewed existing Crisis Team "Guide/Script" Sheet and edited script to add needed details that were identified in audit. (See Attachment: Section B Crisis Guide Script).
4. Re-training of staff was provided on 12/19 & 12/21/2017 and on 4/10 &4/12/2018 to review current protocols regarding the Access Hotline. *Please note, identical crisis staff meetings are held two days in the same week in order to meet with all staff covering the 24/7 Access Hotline. (See Attachment: Section B Training Documentation).
5. Trained staff on revised Crisis Team "Guide/Script"
6. Required posting of the "Guide/Script" at every work station.
7. Managers of Crisis Team checked and ensured the Crisis Team "Guide/Script" was posted at every workstation as required.

The Guide addresses not only the subject matter noted above, but also covers the other routine areas which staff should include in every call.

1. Explanation of service options and how to access services. Is the caller inquiring about routine services(either for the SMHS plan or for routine/non-urgent services with entities other than with the SMHS plan)? Or, is the caller in need of IMMEDIATE services to address an urgent condition or matter (immediate services include: an emergent/urgent Crisis Team response or the response of law enforcement or of medical attention)?
2. If indicated, provision of information regarding how to use the beneficiary problem resolution and fair hearing process. Crisis team practice includes providing either the 1(888) 567-2122 and/or direct number for the identified Quality Management Staff-Karen Gean (805) 973-5331. During normal business hours (M-F, 8am-5pm) the Crisis staff may also warm transfer the caller to the identified Quality Management staff.

PROTOCOL REQUIREMENTS:

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

B10a. 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?

• CCR, title 9, chapter 11, section 1810.405(f)

FINDINGS:

The MHP did not furnish evidence its written logs of initial requests for SMHS includes requests made by phone. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Accessing Specialty Mental Health Services (P&P CA-53) (1/2011); Crisis Team Telephone Log; and Samples of Ventura's' Request for Services.

However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. The logs made available by the MHP did not include all required elements for the DHCS test calls. The table on the following page details the findings:

Protocol question B10.b (1) is deemed in partial compliance.

PLAN OF CORRECTION:

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its written log of initial requests for SMHS (including requests made via telephone, in person or in writing) includes the name of the beneficiary or documents an unsuccessful effort to obtain the name.

VCBH Plan of Correction:

1. Reviewed and clarified the process regarding obtaining the beneficiary's name and/ or documenting why the name was not obtained.
2. Reviewed existing Crisis Team "Guide/Script" Sheet and edited script to add needed details that were identified in audit. (See Attachment: Section B Crisis Team Guide Script).
3. Re-training of staff was provided on 12/19 & 12/21/2017 and on 4/10 &4/12/2018 to review current protocols regarding the hotline. *Please note, identical crisis staff meetings are held two days in the same week in order to meet with all staff covering the 24/7 Access Hotline. (See Attachment: Section B Training Documentation).
4. Trained staff on revised Crisis Team "Guide/Script"
5. Required posting of the "Guide/Script" at every work station.
6. Managers of Crisis Team checked and ensured the Crisis Team "Guide/Script" was posted at every workstation as required
7. Staff are expected to follow the existing protocol for documenting in the Call Log Comments section of the entry the explanation for why the beneficiary's name was not obtained.
8. We are also in the process of developing an electronic version of our written call log into our existing electronic health record that will be ready for use on July 1, 2018. Following the DHCS

audit, we reviewed the need to add a data field which is triggered when a name is not entered. This (mandatory) field requires that a reason be given as to why the beneficiary's name was not obtained.

a. A DRAFT version (screenshot) of our Electronic Health Record is attached (See Attachment: DRAFT Avatar Crisis Team Log Screen Shot). Further edits are necessary before implementation can begin in July 2018. This initial draft version includes one data field as "Name Unavailable/ Not Provided". Further edits will be made to make it more specific, such as, "This writer attempted to get client's name and caller declined/ was unable to provide". Then a "Yes" or "No" box is checked. If "No" is checked, then the entry of the name becomes a mandatory field. This information will be documented in two locations; one for the caller's name and one for the client's name.

PROTOCOL REQUIREMENTS:

B11. 1. Has the MHP updated its Cultural Competence Plan annually in accordance with regulations?

• CCR title 9, section 1810.410 • DMH Information Notice 10-02 and 10-1

FINDINGS:

DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Ventura County Behavioral Health Cultural and Linguistic Competence Update Plan 2015-2018; Cultural & Linguistic Competence Training Plan (7/2015-6/2018); the Cultural and Linguistic Competence Five Year Strategic Plan (2012-2019); and the Latino Equity in Behavioral Health Three Year Strategic Plan 2016-2019. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP's Cultural Competence Plan (CCP) does not meet state regulations for annual updates or covering all required components. For example the CCP had no population assessment, the Cultural Competence Checklist Review (Section 4, Attachment) was an incomplete shell, and the current CCP does not include outreach toward hiring and retaining culturally and logistically competent staff or family and consumers participation in the Cultural Competence Committee. Protocol question B11 is deemed OOC.

PLAN OF CORRECTION:

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it updates its Cultural Competence Plan annually in accordance with regulations to include a response to each of the eight criterion identified by the State.

VCBH Plan of Correction:

As stated in the findings, the Cultural Competence plan that was presented during the System Review by DHCS did not meet the regulatory and/or contractual requirements. However, Ventura County Behavioral Health (VCBH) has updated its Culture Competence Plan, and submitted it to DHCS on Jan. 29, 2018 (See Attachment: Section B Cultural Competence Plan). The updated Cultural Competence Plan addresses each of the eight Criterion identified by the State. An updated Cultural Competence

Committee/Culture, Equity Advisory Committee member roster is included that identifies participation of family members, consumer and other community stakeholders (See Attachment: Section B Equity Advisory Committee Contact Sheet).

In order to ensure compliance with this mandate, Ventura County Behavioral Health has developed a new Cultural Competence Policy. The Cultural Competence Policy provides the procedures to ensure that Ventura County is in compliant with Federal and State regulatory requirements. (See Attachment: Section B Cultural Competence Policy).

SECTION C: AUTHORIZATION

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?

• CFR, title 42, sections 438. 10(c), 438.400(b) and 438.404(c)(2) • MHP Contract, Exhibit A, Attachment I

• CCR, title 9, chapter 11, sections 1830.205(a),(b)(1),(2).(3),

• CFR, title 42, section 438.206(b)(3)1850.210 (a)-(j) and 1850.212 • CCR, title 9, chapter 11, section 1810.405(e)

• DMH Letter No. 05-03

FINDINGS:

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 or the resolution of standard appeals. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Notices of Action (P&P CA 39) (2/2009); and the Grievances Logged Report (2013 till 2017). It was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, though the P&P meets regulatory guidelines, DHCS reviewed a sample of 30 grievances and 6 appeals and found 17 late resolutions one of which was accompanied by a NOA-D for a compliance rate of 6%. Protocol question C6d is deemed in partial compliance.

PLAN OF CORRECTION:

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a written NOA-D to the beneficiary when the MHP fails to act within the timeframes for the disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

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VCBH Plan of Correction:

1. 12/18/17 - MHP created and filled a QM/UR Manager position aimed at increasing structure and oversight toward consistent compliance with state regulations

2. 4/9/18 - All Grievance and Appeal responsibilities have shifted from the previous designated employee to the current UR Interim Nursing Manager, who will be working in conjunction with the QM/UR Manager to establish compliance and oversight protocols

3. Policies and Procedures are being revised to meet Managed Care Final Rule requirements per MHSUDS INFORMATION NOTICE NO.: 18-010E

   a. P&P QM-18 - Beneficiary Problem Resolution Process: Grievances, Appeals and Expedited Appeals policy now includes a templated NOABD Grievance and Appeal Timely Resolution Notice, which replaces the NOA-D (Delays in Grievance/Appeal Processing) (See Attachments: Section C PNP QM-18 DRAFT; Section C NOABD Grievance/Appeal Timely Resolution)

4. A system to track compliance with all Grievance and Appeal timelines is being developed:

   a. Short-term solution (4/16/18): A spreadsheet is being implemented to track and monitor adherence to QM-18 Grievance/Appeal resolution timelines (See Attachment: Section C Grievance and Appeal Tracking Log)

   b. Long-term solution (projected for 8/1/18): The Grievances and Appeals log on the Electronic Medical Record AVATAR system will be revised to include capacity to track and report on compliance with all Problem Resolution process timelines.

SECTION D: BENEFICIARY PROTECTION

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?

• CFR, title 42, section 438.408(a)(b)(1)(2)(3)

•CCR, title 9, chapter 11, section 1850.206(b)

• CCR, title 9, chapter 11, section 1850.207(c) • CCR, title 9, chapter 11, section 1850.208.

FINDINGS:

DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Beneficiary Problem Resolution Process (P&P QM 18); Grievance, Appeals and Expedited Appeals; Grievances Logged Report; MHP and the Appeals Logged Report. The policy meets regulatory timeframes. However, in addition to reviewing these documents, DHCS inspected a sample of grievances and appeals to verify compliance with regulatory timeframes. The sample findings are detailed below:

Protocol question D3a1 is deemed in partial compliance and D3a2 is deemed OOC.

PLAN OF CORRECTION:

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it ensures each grievance, appeal, and expedited appeal is resolved within established timeframes.

VCBH Plan of Correction:

1. 12/18/17 - MHP created and filled a QM/UR Manager position aimed at increasing structure and oversight toward consistent compliance with state regulations

2. 4/9/18 - All Grievance and Appeal responsibilities have shifted from the previous designated employee to the current UR Interim Nursing Manager, who will be working in conjunction with the QM/UR Manager to establish compliance and oversight protocols

3. Policies and Procedures are being revised to meet Managed Care Final Rule requirements per MHSUDS INFORMATION NOTICE NO.: 18-010E

    a. P&P QM-18 - Beneficiary Problem Resolution Process: Grievances, Appeals and Expedited Appeals DRAFT policy includes current timelines and protocols (See Attachment: Section C QM-18 DRAFT)

4. A system to track compliance with all Grievance and Appeal timelines is being developed:

    a. Short-term solution (4/16/18): A spreadsheet is being implemented to track and monitor adherence to QM-18 Grievance/Appeal resolution timelines (See Attachment: Section C Grievance and Appeal Tracking Log)

    b. Long-term solution (projected for 8/1/18): The Grievances and Appeals log on the Electronic Medical Record AVATAR system will be revised to include the capacity to track compliance with all Grievance and Appeal requirements and timelines.

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PROTOCOL REQUIREMENTS:

D4. Regarding notification to beneficiaries:

D4a. 1) 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 appeal to the beneficiary in writing? 2) Is the MHP notifying beneficiaries, or their representatives, of the appeal disposition, and is this being documented?

D4c. 1) Does the MHP provide written acknowledgement of each expedited appeal to the beneficiary in writing? 2) Is the MHP notifying beneficiaries, or their representatives, of the expedited appeal disposition, and is this being documented?

•CFR, title 42, section 438.406(a) (2)

• CCR, title 9, chapter 11, section 1850.205(d) (4)

• CFR, title 42, section 438.408(d) (1) (2)

•CCR, title 9, chapter 11, sections 1850.206(b),(c), 1850.207(c),(h), and 1850.208(d),(e)

FINDINGS:

DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Beneficiary Problem Resolution Process for Grievances, Appeals, and Expedited Appeals (P&P # QM 18) (2/2016); Acknowledgment of Receipt templates; Notice of Decision/How to File for a State Fair Hearing; and the Appeals Log and Detail Report.

However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP's written response noted the missing acknowledgement and disposition letters. DHCS provided the MHP the opportunity to locate further evidence, but the MHP did not provide sufficient evidence that all required acknowledgment and disposition letters were given to the beneficiary in writing.

In addition, DHCS inspected a sample of grievances, appeals to verify compliance with regulatory requirements and found acknowledgement and decision letters were missing and that some letters accompanying grievances and appeals were copies of letters to other beneficiaries. The sample from FY 2014/15 and 2015/16 findings are detailed below:

Protocol questions D4a1, D4a2, D4a and D4b are deemed in partial compliance.

PLAN OF CORRECTI ON:

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides written acknowledgement and notifications of dispositions to beneficiaries for each grievance and appeal.

VCBH Plan of Correction:

1. 12/19/17 - MHP has created and filled a designated QM/UR Manager position to provide increased oversight and structure in aim of meeting all state compliance regulations

2. 4/9/18 - All Grievance and Appeal responsibilities have shifted to the UR Interim Nursing Manager, who will be closely supervised to ensure compliance with Grievance and Appeal response requirements and timelines

3. Policies and Procedures are being revised to meet Managed Care Final Rule requirements per MHSUDS INFORMATION NOTICE NO.: 18-010E

    a. P&P QM-18 - Beneficiary Problem Resolution Process: Grievances, Appeals and Expedited Appeals policy includes current timelines and protocols regarding acknowledgment and resolution letters. (See Attachment: Section D QM-18 DRAFT)

4. A system to track compliance with all Grievance and Appeal timelines is being developed:

    a. Short-term solution (4/16/18): A spreadsheet is being implemented to track and monitor adherence to QM-18 Grievance/Appeal resolution timelines (See Attachment: Section D Grievance and Appeal Tracking Log)

    b. Long-term solution (projected for 8/1/18): The Grievances and Appeals log on the Electronic Medical Record AVATAR system will be revised to include the capacity to track compliance with all Grievance and Appeal notification requirements and timelines.

SECTION I: QUALITY IMPROVEMENT

PROTOCOL REQUIREMENTS:

I6. Regarding the QM Work Plan:

I6a. Does the MHP have a QM Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed?

I6b. Does the QM Work Plan include evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review?

I6c. Does the QM Work Plan include evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service?

I6d. Does the QM Work Plan include a description of completed and in-process QM activities, including: 1} Monitoring efforts for previously identified issues, including tracking issues over time? 2) Objectives, scope, and planned QM activities for each year? 3) Targeted areas of improvement or change in service delivery or program design?

I6e. Does the QM Work Plan include a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals for: 1) Responsiveness for the Contractor's 24-hour toil-free telephone number? 2) Timeliness for scheduling of routine appointments? 3) Timeliness of services for urgent conditions? 4) Access to after-hours care?

I6f. Does the QM Work Plan include evidence of compliance with the requirements for cultural competence and linguistic competence?

• CCR, title 9, chapter 11, section 1810.440(a)(5)

•MHP Contract, Exhibit A, Attachment I

• DMH Information Notice No. 10-17, Enclosures, Pages 18 & • CCR, tit. 9, § 1810.410

19, and DMH Information Notice No. 10-02, Enclosure, Page

• CFR, title 42, Part 438-Managed Care, sections 438.204, 23 438.240 and 438.358.

FINDINGS:

DHCS reviewed the following documentation presented by the MHP as evidence of compliance: VCBH QI Performance Program Plan (2015/16); QI Workplan for 2015/2016 Results Evaluation; Cultural Competence Plan (2015-18); Sample Test Call

Reports (12/2016); Current Provider Test Call procedure with report form and instructions; Timeliness Self-Assessment; Access to Services Workgroup Study including the Project

Charter and sample metric analysis. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements.

Specifically, the QM Work Plan did not include a description of mechanisms to assess the accessibility of after-hours care. Protocol question 16e4 is deemed OOC.

PLAN OF CORRECTION:

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has a QM/QI Work Plan

covering the current contract cycle with descriptions of mechanisms implemented to assess the accessibly of afterhours care.

VCBH Plan of Correction:

VCBH provides access to request for services, crisis intervention, and information 24/7 through our Access Line. The Access Line provides services for consumers who may be experiencing a Mental Health Crisis through a toll free number 1-866-998-2243. The Crisis Team is staffed 24/7. Experienced and trained mental health staff will provide assistance and support on the phone and, if indicated, will respond in person, generally within one hour.

For consumers wanting to access Mental Health Services, the same line provide access to a qualified mental health specialist who will conduct a screening interview to discuss what services best fit the consumers' needs.

If VCBH services appear to be the best possible option, he/she will be scheduled for a comprehensive assessment with a mental health clinician. If VCBH services appear not to be the best option, consumer will be provided with alternative resources in their community.

*See Attachment: Section I Quality Improvement

SECTION J: MENTAL HEALTH SERVICES ACT (MHSA)

PROTOCOL REQUIREMENTS:

J5e. 1) Does the County provide FSP services to all age groups (i.e., older adults, adults, transition-age youth, and children/youth)?

• CCR, title 9, chapter 14, section 3620

FINDINGS:

The County did not furnish evidence that it provides FSP services to all age groups (i.e., older adults, adults, transition-age youth, and children/youth). DHCS reviewed the following documentation presented by the County as evidence of compliance: Safety Plan (P&P CA-59) (5/2011); and Full-Service Partnerships (P&P CA-67) (10/2013), though the documentation states the MHP's Full Service Partnerships applies to the "Adult Services

Division and the Youth and Family Services Division," the MHP told us onsite that it has not yet begun these services for the youth in their system. For that reason, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, processes for youth FSP have not been instituted. Protocol question J5e is deemed OOC.

PLAN OF CORRECTION:

The County must submit a POC addressing the OOC findings for this requirement. The County is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides FSP services to all age groups (i.e., older adults, adults, transition-age youth, and children/youth).

VCBH Plan of Correction:

The Ventura County Behavioral Health Department in collaboration with Ventura County Probation Agency and working in partnership with the Ventura County Juvenile Court, the Ventura County Public Defender's office, the Ventura County District Attorney's office, the Ventura County Office of Education and the Public Health Department developed and successfully launched the INSIGHTS program in July of 2017. This Full Service Partnership serves youth ages 13-15 years old and Transitional Age Youth ages 16-17 years old. The program was developed in response to the needs of a population of juvenile offenders who are diagnosed with severe emotional disturbances and, potentially, co-occurring substance use disorders who do not respond well to existing dispositional alternatives and often linger on probation or revolve in and out of custodial facilities and/or out-of-home placements. The program will utilize a multidisciplinary approach to provide intensive treatment and case management services to these youths. Through a collaborative process, coordinated services are offered to the youth/caregivers which may include comprehensive mental health services, substance abuse services, peer and parent support, and other county and community-based support resources. With focus on the special needs of these high-risk youth and their families, interagency team members will work in strong collaboration to develop individualized multidisciplinary case plans with the overarching goals of reducing incarcerations, hospitalizations, and other out-of-home placements and providing those supports necessary for these youths to be successful in their home communities (See Attachment: Section J Mental Health Services Act).

SECTION C: AUTHORIZATION-SURVEY

PROTOCOL REQUIREMENTS:

C4d. SURVEY ONLY

1) Does the MHP ensure timely transfer within 48 hours of the authorization and provision of SMHS for a child who will be placed "out of county"?

2) Does the MHP have a mechanism to track the transfer of the authorization and provision of services to another MHP?

• CCR, title 9, chapter 11, section 1830.220(b)(3) and (b)(4)(A);sections 1810.220.5, 1830.220 (b)(3), and b(4)(A),

• WIG sections, 11376, 16125, 14716; 14717, 14684, 14718and 16125

• DMH Information Notice No. 09-06,

•DMH Information Notice No. 97-06

•DMH Information Notice No. 08-24

SURVEY FINDING:

DHCS reviewed the following documentation provided by the MHP for this survey item: Authorization of Services (P&P CA-55); and the Regulation Processes Workgroup Presentation. The documentation lacks specific elements to demonstrate compliance with Federal and State requirements. Specifically, the MHP noted a 14-day rather than the 48-hour requirement for authorization and provision of SMHS for a child placed out of county.

SUGGESTED ACTIONS:

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Update authorization policies and procedures to reflect transfer for a child placed out of county within 48 hours of authorization and provision of service and carefully track the timeliness of that authorization and the first provision of service.

PROTOCOL REQUIREMENTS:

C4e. SURVEY ONLY

1) Does the MHP ensure an assessment has been conducted and authorization of services occurs within 4 business days of receipt of a referral for SMHS for a child by another MHP?

2) Does the MHP have a mechanism to track referrals for assessments and authorizations of services for children placed in its county?

• CCR, title 9, chapter 11, section 1830.220(b)(3) and (b)(4)(A);sections 1810.220.5, 1830.220 (b)(3), and b(4)(A),

• WIG sections, 11376, 16125, 14716; 14717, 14684, 14718 and 16125

• DMH Information Notice No. 09-06

•DMH Information Notice No. 97-06

•DMH Information Notice No. 08-24

SURVEY FINDING:

DHCS reviewed the following documentation provided by the MHP for this survey item: Authorization of Services (P&P CA-55) (2/2011); Authorization of Services (IHBS) (11/14); and the Regulation Processes Workgroup Presentation. The documentation lacks specific elements to demonstrate

compliance with federal and State requirements. Specifically, a timeframe of four (4) business days from referral to assessment and authorization of services is lacking in the documentation.

SUGGESTED ACTIONS:

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Update service authorization policies and procedures to reflect the required referral within four (4) business days from receipt of a referral for SMHS for a child by another MHP and track these referrals.

SECTION H: PROGRAM INTEGRITY-SURVEY

PROTOCOL REQUIREMENTS:

H4b. SURVEY ONLY: Does the MHP require its employees or contract providers to consent to criminal background checks as a condition of enrollment per 42 CFR 455.434(a)?

• CFR, title 42, sections 455. 101,455. 104, and 455.416

•MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements

SURVEY FINDING:

DHCS reviewed the following documentation provided by the MHP for this survey item: The Kids and Families Together Live Scan Background and Fingerprint Check Instructions; and the Casa Pacifica Centers for Children and Families Background and Fingerprint Check Policy. The documentation lacks specific elements to demonstrate compliance with federal and State requirements. Specifically, the MHP provided evidence that, though some of its contractors require a criminal background check, the MHP does not require criminal background checks as a condition of enrollment. Additionally, the MHP's written response to this question was, "No, we do not."

SUGGESTED ACTIONS:

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Ensure providers are required to consent to criminal background checks as a condition of enrollment and add this requirement to provider contracts.

VCBH Plan of Correction:

Employees:

A pre-employment background check is conducted on all potential candidates and assists with the determination of appropriateness for employment with VCBH (See Attachment: Section H Background Application). In conjunction with the application for employment, Ventura Health Care Agency, Human Resource Department, utilizes the services of EMPLOYEE RELATIONS, INC. to conduct a background investigation regarding the character, general reputation, personal characteristics, and mode of living of

candidates. The investigative report includes inquiry into past employment, education, and activities, including, but not limited to public records, credit history, criminal background information, and driving record.

Contractors:

Ventura County Behavioral Health (VCBH) included language in its FY 2017-18 contracts that requires contract providers to consent to criminal background checks as a condition of enrollment per 42 CFR 455.434(a) (See Attachment: Section H Revised Criminal Background Check Contract Language). This contract language was recently revised to include feedback received from the Department of Health Care Services (DHCS) Program Oversight & Compliance Branch Chief, Lanette Castleman. The original and revised contract language/sections are attached for Department of Health Care Services (DHCS) review. The revised contract language was approved at the April 17, 2018 Ventura County Board of Supervisors board meeting. VCBH is currently working on processing formal administrative amendments to incorporate the revised language.

PROTOCOL REQUIREMENTS:

H4c. SURVEY ONLY: Does the MHP require employees and contract providers, or any person with a 5 percent or more direct or indirect ownership interest in the provider to submit a set of fingerprints per 42 CFR 455.434(b)(1)?

• CFR, title 42, sections 455. 101,455.104, and 455.416 • MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements

SURVEY FINDING:

DHCS reviewed the following documentation provided by the MHP for this survey item: The Kids and Families Together Live Scan Background and Fingerprint Check Instructions; and the Casa Pacifica Centers for Children and Families Background and Fingerprint Check

Policy. The documentation lacks specific elements to demonstrate compliance with federal and State requirements. Specifically, the MHP has not required persons with a 5 percent or more direct or indirect ownership interest in an MHP provider to submit a set of fingerprints. Additionally, the MHP's written response to this question was, "No, we do not."

SUGGESTED ACTIONS:

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Require any person with a 5 percent or more direct or indirect ownership interest in the provider to submit a set of fingerprints and add language regarding this requirement to their provider contracts.

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VCBH Plan of Correction:

Employees:

The Ventura County Health Care Agency is responsible for ensuring employees complete the direct or indirect ownership interest form and follow 42 CFR 455.434(b)(1) as appropriate (See Attachment: Section H Disclosure of Interest for Employees). As a government employee, the Political Reform Act requires employees in the State upon hire and annually to publicly disclose personal assets and income on Form 700. The form is filed every year (No later than April 1) to the Clerk of the Board, as well as when an employee is assuming or leaving office. This can be completed through an on-line eDisclosure system or by mailing in the form (See Attachment: Section H eFiler Quick Reference).

However, if the form is submitted on an originally signed paper copy that is available from the Fair Political Practices Commission (FPPC) at www.fppc.ca.gov/forms.html, it must be mailed to:

Clerk of the Board
800 S. Victoria Avenue, L #1920
Ventura, CA 93009

The FPPC is available to assist with completing the form. Information is available on their website (www.fppc.ca.gov), or at (866) 275-3772 or by emailing advice@fppc.ca.gov.

Contractors:

VCBH included language in its FY 2017-18 contracts that requires contract providers, or any person with a 5 percent or more direct or indirect ownership interest in the provider to submit a set of fingerprints per 42 CFR 455.434(b)(1) (See Attachment: Section H Revised Criminal Background, Fingerprinting, and SSADMF Contract Language). This contract language was recently revised to include feedback received from the DHCS Program Oversight & Compliance Branch Chief, Lanette Castleman. The original and revised contract language/sections are attached for DHCS review (See Attached: Section H FY17-18 Contract Language-ANKA (MHRC). The revised contract language was approved at the April 17, 2018 Ventura County Board of Supervisors board meeting. VCBH is currently working on processing formal administrative amendments to incorporate the revised language.

PROTOCOL REQUIREMENTS:

H5a3. SURVEY ONLY: Is there evidence that the MHP has a process in place to verify new and current (prior to contracting/employing) providers and contractors are not in the Social Security Administration's Death Master File?

• CFR, title 42, sections 438 .214(0), 438.610, 455.400-455 .470, 455.436(8)

• DMH Letter No. 10-05

• MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements

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SURVEY FINDING:

DHCS reviewed the following documentation provided by the MHP for this survey item: National Plan and Provider (AD-35); and the Managed Care Individual and Group Provider Credentialing and Re-credentialing. The MHP documented that they check the Inspector General Exclusion List and the Medi-Cal Suspended and Ineligible Providers List, but has not yet begun to check the Social Security Administrations' Death Master File. The documentation does not provide sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS:

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Implement a process to verify new and current providers and contractors are not in the Social Security Administration's Death Master File.

VCBH Plan of Correction:

Employees:

The Ventura County Health Care Agency (VCHCA) Medical Staff Office will be responsible for verifying all licensed VCBH employees are not listed on the Social Security Administration Death Master File (SSADMF) database prior to employing. The VCHCA Compliance Office contracts with Sanctioncheck.com to complete all required sanction checks—this additional sanction check requirement was added to the County contract in March of 2018. In mid-March of 2018, a search of all existing VCBH employees was conducted and no issues were identified. Verification of the completion of this database check was provided to VCBH on 3-30-18 (See Attachment: Section H Social Security Administration Death Master File Check Summary). Aside from the attached excel spreadsheet, Sanctioncheck.com does not currently provide a formal report or attestation letter that can serve as evidence of the completion of the SSADMF database check. The VCHCA Compliance Office is in the process of working with Sanctioncheck.com to get a formal report or attestation letter for our use in documenting and reporting completion of the SSADMF database check. In addition, the VCHCA Compliance Office is in the process of formally revising its policies to reflect the new SSADMF database verification requirement.

Contractors:

VCBH included language in its FY 2017-18 contracts that requires contract providers to verify that none of their providers are listed in the SSADMF. Contract providers are required to check the SSADMF database prior to: (1) contracting, (2) before contract renewal, and (3) upon request of the County. Please note that this language was recently revised to include the provision that contract providers check the SSADMF *prior to employing staff.* This additional contract language was added to ensure that all contract provider staff are checked in between the database check done prior to contracting and contract renewal. VCBH contract providers are required to submit verification of compliance with these requirements to VCBH. VCBH also conducts site review audits to verify compliance. VCBH reached out during the month of March and April to ensure compliance with this requirement and provide guidance to contract providers. Attached for DHCS review is the: (1) original and revised contract language/sections containing these provisions (revised contract language was approved at the April 17, 2018 Ventura County Board of

Supervisors board meeting), (2) verification of SSADMF database checks from an Adult and Youth and Family contract provider, and (3) email from VCBH to a contract provider (Anka Behavioral Health, Inc.) providing SSADMF database verification guidance and requiring compliance.

The process for fee for Service contractors (psychiatrists) deviates from the process described above. With respect to these providers, VCBH will be conducting the SSADMF database check during the credentialing and re-credentialing process which occurs prior to contracting and contract renewal. To become compliant with the SSADMF database check requirement, VCBH is in the process of collecting the information needed from the fee for Service contractors to conduct this database check.

See Attachments: Section H Revised Criminal Background, Fingerprinting, and SSADMF Contract Language; Section H FY17-18 Contract Language-ANKA (MHRC); Section H Social Security Administration Death Master File Check Summary; Section H Attestation reg SSADMF to Provider Casa Pacifica; Section H Provider SSADMF Database Verification and Guidance Letter; Section H Email to Contractor ANKA reg SSADMF.

SECTION K: CHART REVIEW

Medical Necessity

PROTOCOL REQUIREMENTS:

1. Does the beneficiary meet all three (3) of the following medical necessity criteria for reimbursement (1a, 1b, and 1c. below)?
    a. The beneficiary has a current ICD diagnosis which is included for non-hospital SMHS in accordance with the MHP contract?
    b. The beneficiary, as a result of a mental disorder or emotional disturbance listed in 1a, must have at least one (1) of the following criteria (1-4 below):
        i. A significant impairment in an important area of life functioning.
        ii. A probability of significant deterioration in an important area of life functioning.
        iii. A probability that the child will not progress developmentally as individually appropriate.
        iv. For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate.
    c. Do the proposed and actual intervention(s) meet the intervention criteria listed below:
        i. The focus of the proposed and actual intervention(s) is to address the condition identified in No. 1b. (1-3) above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate per No. 1b(4).
        ii. The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (A, B, C, or D):

1. A. Significantly diminish the impairment.
2. B. Prevent significant deterioration in an important area of life functioning.
3. C. Allow the child to progress developmentally as individually appropriate.
4. D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.

d. The condition would not be responsive to physical health care based treatment.

• CCR, title 9, chapter 11, section 1830.205 (b)(c) • CCR, title 9, chapter 11, section 1840.314(d) • CCR, title 9, chapter 11, section1830.210 • CCR, title 22, chapter 3, section 51303(a) • CCR, title 9, chapter 11, section 1810.345(c) • Credentialing Boards for MH Disciplines • CCR, title 9, chapter 11, section 1840.112fb)(1-4)

FINDING 1c-1:

The medical record associated with the following Line numbers did not meet the medical necessity criteria since the focus of the proposed interventions did not address the mental health condition as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A):

- Line numbers [redacted]. RR3, refer to Recoupment Summary for details

PLAN OF CORRECTION 1c-1:

The MHP shall submit a POC that indicates how the MHP will ensure that interventions are focused on a significant functional impairment that is directly related to the mental health condition as specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(A).

VCBH Plan of Correction K1c-1:

1. Currently, all new and targeted existing staff participate in Clinical Documentation Training. (See Attachment: Section K Clinical Documentation Training, slides # 3, 5, 6, 7, 10, 13, 18, 20, 28, 38, 45, 48, & 50.)
    a. Noted slides address the provision of interventions to correct or ameliorate functional impairment related to a mental health condition.
2. A comprehensive Clinical Documentation Training and users' manual is being developed to augment the already-established clinical documentation training (Projected 12/31/18).
    a. All new and existing staff will then be required to participate in this revised training, followed by annual boosters to focus on identified documentation deficiencies.
    b. Training will specifically reinforce the need to ensure interventions are focused on addressing functional impairment related to the mental health condition.
3. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
    a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
        i. QR reviews will identify and disallow unauthorized services and

further serve as training for Clinic Administrators to use for line staff

b. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues

Assessment *(Findings in this area do not result in disallowances. Plan of Correction only.)*

PROTOCOL REQUIREMENTS:

2. Regarding the Assessment, are the following conditions met:

2A. 1) Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness?

2) Has the Assessment been completed in accordance with the MHP's established written documentation standards for frequency?

• CCR, title 9, chapter 11, section 1810.204 • CCR, title 9, chapter 11, section 1840.112(b)(1-4) • CCR. title 9, chapter 11. section 1840.314{d){e) • CCR, title 9, chapter 4, section 851- Lanterman-Petris Act • MHP Contract, Exhibit A, Attachment I

FINDINGS 2a:

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

1) One or more assessments were not completed within the timeliness and frequency requirements specified in the MHP's written documentation standards. The following are specific findings from the chart sample:

- Line numbers [redacted]: There was no initial assessment found in the medical record. *During the review, MHP staff were given the opportunity to locate the missing assessment but could not locate the document in the medical record.*
- Line number [redacted]: The initial assessment was completed late.
- Line number [redacted]: The updated assessment was completed late.

PLAN OF CORRECTION 2a:

The MHP shall submit a POC that indicates how the MHP will ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.

VCBH Plan of Correction K2a1-2:

1. PNP CA47 delineates required timeliness and frequency of initial assessments and assessment updates. (See Attachment: Section K CA-47: Initial Assessment, Assessment Update)

   a. All new VCBH and Contracted staff will be required to train on this policy during initial orientation (Projected 12/31/18).
2. An Avatar report to track Client Assessment Status (5816) has been created to identify all due and overdue assessments/updates. (See Attachment: Section K Client Assessment Status 5816)
3. A comprehensive Clinical Documentation Training and users' manual is being developed to augment the already-established clinical documentation training (projected 12/31/18).
   a. All new and existing staff will then be required to participate in this revised training, followed by annual boosters to focus on identified documentation deficiencies.
   b. Training will specifically reinforce the timeliness and frequency requirements for initial assessments and assessment updates.
4. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
   a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
      i. QR reviews will identify and disallow unauthorized services
   b. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues

PROTOCOL REQUIREMENTS:

2b. Do the Assessments include the areas specified in the MHP Contract with the Department?

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

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

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

4) 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

5) 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 must include documentation of the absence or presence of allergies or adverse reactions to medications and documentation of an informed consent for medications;

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

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

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

9) A mental status examination;

10) A Complete Diagnosis; A diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.

• CCR, title 9, chapter 11, section 1810.204 • CCR, title 9, chapter 11, section 1840.112(b)(1-4) • CCR title 9 chapter 11 section 1840.314(d)(e) • CCR, title 9, chapter 4, section 851- Lanterman-Petris Act • MHP Contract, Exhibit A, Attachment I

FINDING 2b:

One or more of the assessments reviewed did not include all of the elements specified in the MHP Contract with the Department. The following required elements were incomplete or missing:

1) Medical History: Line number [redacted].
2) A mental status examination: Line number [redacted].

PLAN OF CORRECTION 2b:

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

VCBH Plan of Correction K2b4, K2b9:

1. PNP CA47 delineates required elements to be included in the initial assessments and assessment updates. (See Attachment: Section K CA-47: Initial Assessment, Assessment Update)
    a. All new VCBH and Contracted staff will be required to train on this policy during initial orientation (by 12/31/18).
2. A comprehensive Clinical Documentation Training and users' manual is being developed to augment the already-established clinical documentation training (projected 12/31/18).
    a. All new and existing staff will then be required to participate in this revised training, followed by annual boosters to focus on identified documentation deficiencies.
    b. Training will specifically reinforce the required elements to be included in the initial assessments and assessment updates.

3. A workgroup will be established to create a mechanism within the AVATAR EHR to ensure completion of all required elements prior to ability to finalize assessments (Projected 12/31/18).
4. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
    a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
        i. QR reviews will identify and disallow unauthorized services
    b. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues

Medication Consent (Findings in this area do not result in disallowances.Plan of Correction only.)

PROTOCOL REQUIREMENT:

3. Regarding medication consent forms:

3a. Did the provider obtain and retain a current written medication consent form signed by the beneficiary agreeinq to the administration of each prescribed psychiatric medication?

• CCR, title 9, chapter 11, section 1810.204 • CCR, title 9, chapter 11, section 1840.112(b)(1-4) • CCR, title 9, chapter 11, section 1840.314(d)(e) • CCR, title 9, chapter 4, section 851- Lanterman-Petris Act • MHP Contract, Exhibit A, Attachment I

FINDING 3a:

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

- Line number [redacted]: There was no written medication consent form found in the medical record. *During the review, MHP staff was given the opportunity to locate the missing medication consent form but was unable to locate it in the medical record.*

PLAN OF CORRECTION 3a:

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

1) A written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP.
2) Written medication consent forms are completed in accordance with the MHP's written documentation standards.

VCBH Plan of Correction K3a:

1. PNP PH-10 has been revised to require written medication consent upon initial prescription.

Annual renewal of the consent requirement has been removed, unless changes are made. (See Attachment: Section K PH-10: Consent for Psychotropic Medication)

2. Training during prescribers' monthly meetings will specifically reinforce the requirement of attaining required written medication consents (See Attachment: Section K Monthly SCPG Provider Meeting Minutes).
3. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
    a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
        i. QR reviews will identify and disallow unauthorized services
    b. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues
4. The MHP will create an electronic psychotropic medication consent form to be signed digitally by the client/guardian. This will facilitate improved tracking and oversight. (Projected 12/31/18)

Client Plans

PROTOCOL REQUIREMENT:

4a. 1) Has the client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition?

• CCR, title 9, chapter 11, section 1810.205.2 . • CCR, title 9, chapter 11, section 1810.254 CCR, title 9, chapter 11, section 1810.440(c)(1)(2) • CCR, title 9, chapter 11, section 1840.112(b)(2-5) • CCR, title 9, chapter 11, section 1840.314(d)(e) • DMH Letter 02-01, Enclosure A • WIC, section 5751.2 • MHP Contract, Exhibit A, Attachment I • CCR, title 16, Section 1820.5 • California Business and Profession Code, Section 4999.20

FINDING 4a-2:

The client plan was not updated at least annually or when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department and as specified in the MHP's documentation standards):

- Line numbers [redacted]: There was a lapse between the prior and current client plans and therefore, there was no client plan in effect during a portion or all of the audit review period. RR6, refer.to Recoupment Summary for details.

  The MHP should review all services and claims identified during the audit for which there was no client plan in effect and disallow those claims as required.

PLAN OF CORRECTION 4a-2:

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

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1) Ensure that client plans are completed at least on an annual basis as required in the MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.

2) Ensure that all types of interventions/service modalities provided and claimed are recorded as proposed interventions on a current client plan.

3) Ensure that non-emergency services are not claimed when:

   a) A client plan has not been completed.

   b) The service provided is not included in the current client plan.

4) Provide evidence that all services identified during the audit that were claimed outside of the audit review period for which no client plan was in effect are disallowed.

   a) All claims for services identified during the audit have been voided as shown on the attached general ledger (See Attachment: Section K POC Findings4a-2 Line# [redacted]). This shows that the services are marked as "VOID" and ready to process for SDMC recoupment of payment.

   b) Regarding Line [redacted]; Service dates [redacted] where payments received have been placed in "VOID" and ready to process for SDMC recoupment of payment. Service dates [redacted] were previously adjusted and not submitted to SDMC for payment.

   c) Regarding Line [redacted]; Service dates [redacted] where payments were received have been placed in "VOID" and ready to process for SDMC recoupment of payment.

VCBH Plan of Correction K4a1:

1. Currently, all new and targeted existing staff participate in Clinical Documentation Training. (See Attachment: Section K Clinical Documentation Training, slides # 12 & 58.)
   a. Noted slides address the timeliness requirements for completion of client plans.
2. PNP CA64 delineates required timeliness for completing initial and annual Client Plans. (See Attachment: Section K CA-64: Client Plan/Individual Services and Supports Plan)
   a. All new VCBH and Contracted staff will be required to train on this policy during initial orientation (Projected 12/31/18).
3. Avatar reports are emailed weekly to clinic administrators to track treatment plans that are either due, overdue or completed but still in DRAFT form. (See Attachment: Section K Treatment Plan End Date [redacted]); and Attachment Section K Client MH Plans in DRAFT 5691)
4. A comprehensive Clinical Documentation Training and users' manual is being developed to augment the already-established clinical documentation training (projected 12/31/18).
   a. All new and existing staff will then be required to participate in this revised training, followed by annual boosters to focus on identified documentation deficiencies.
   b. Training will specifically reinforce the required timelines in creating initial and

updated treatment plans and prohibition of billing for services that are not on a current treatment plans.

5. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
    a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
        i. QR reviews will identify and disallow unauthorized services (See Attachment: Section K Disallowance of services with missing client plans) (Doreen - Evidence that all services identified during the audit that were claimed outside of the audit review period for which no client plan was in effect are disallowed.)
    b. Disallowance Dashboard management tool has been developed to identify disallowed units due to missing authorized treatment plans per specific programs/staff (See Attachment: Section K VCBH MH Disallowance DASHBOARD)
    c. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues

PROTOCOL REQUIREMENT:

4b. Does the client plan include the items specified in the MHP Contract with the Department?

1) Specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diaqnosis.

2) The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.

3) The proposed frequency of intervention(s).

4) The proposed duration of intervention(s).

5) Interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.

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

7) Be consistent with the qualifying diagnoses.

• CCR, title 9, chapter 11, section 1810.205.2 • CCR, title 9, chapter 11, section 1810.254 CCR, title 9, chapter 11, section 1810.440(c)(1)(2) • CCR, title 9, chapter 11, section 1840.112(b)(2-5) • CCR, title 9, chapter 11, section 1840.314(d)(e) • DMH Letter 02-01, Enclosure A • WIG, section 5751.2 • MHP Contract, Exhibit A, Attachment I • CCR, title 16, Section 1820.5 • California Business and Profession Code, Section 4999.20

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FINDING 4b:

The following Line numbers had client plans that did not include all of the items specified in the MHP Contract with the Department:

4b-2) One or more of the proposed interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded on the client plan (e.g. "Medication Support Services," "Targeted Case Management," "Mental Health Services," etc.). Line numbers [redacted]

PLAN OF CORRECTION 4b:

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

1) (4b-2.) All mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or modality of service (e.g. "therapy", "medication", "case management", etc.).

VCBH Plan of Correction K4b2:

1. The Executive Team is working with the EMR team to add free text data fields to the treatment plan to allow the ability to include detailed descriptions of proposed interventions/modalities per regulation guidelines.
2. A comprehensive Clinical Documentation Training and users' manual is being developed to augment the already-established clinical documentation training (projected 12/31/18).
    a. All new and existing staff will then be required to participate in this revised training, followed by annual boosters to focus on identified documentation deficiencies.
    b. Training will specifically target the requirement to document detailed descriptions of proposed interventions/modalities on treatment plans.
3. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
    a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
        i. QR reviews will monitor to ensure demonstration of detailed descriptions of proposed interventions/modalities on treatment plans.
    b. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues

PROTOCOL REQUIREMENT:

4d. Regarding the beneficiary's participation and agreement with the client plan:

1) Is there documentation of the beneficiary's degree of participation and agreement with the client plan as evidenced by, but not limited to:

a. Reference to the beneficiary's participation in and agreement in the body of the client plan; or

b. The beneficiary signature on the client plan; or

c. A description of the beneficiary's participation and agreement in the medical record.

2) Does the client plan include the beneficiary's signature or the signature of the beneficiary's legal representative when:

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

b. The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS?

3) When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, does the client plan include a written explanation of the refusal or unavailability of the signature?

• CCR, title 9, chapter 11, section 1810.205.2 • CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c)(1)(2) • CCR, title 9, chapter 11, section 1840.112(b)(2-5) • CCR, title 9, chapter 11, section 1840.314(d)(e) • DMH Letter 02-01. Enclosure A • WIG, section 5751.2 • MHP Contract, Exhibit A, Attachment I • CCR, title 16, Section 1820.5 • California Business and Profession Code, Section 4999.20

FINDING 4d-1:
There was no documentation of the beneficiary's or legal representative's degree of participation in and agreement with the plan, and there was no written explanation of the beneficiary's refusal or unavailability to sign the plan, as required in the MHP Contract with the Department:

- Line number [redacted]: The beneficiary or legal representative was required to sign the client plan per the MHP Contract with the Department and the MHP's written documentation standards. However, the signature was missing.
  RR7, refer to Recoupment Summary for details

PLAN OF CORRECTION 4d:
The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that each beneficiary's participation and agreement is obtained as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2).
2) Ensure that the beneficiary's signature is obtained on the client plan as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2)(A)(B).
3) Ensure that services are not claimed when the beneficiary's:
   a) Participation in and agreement with the client plan is not obtained and the reason for refusal is not documented.
   b) Signature is not obtained when required or not obtained and the reason for

refusal is not documented.

VCBH Plan of Correction K4d1:

1. Currently, all new and targeted existing staff participate in Clinical Documentation Training. (See Attachment: Section K Clinical Documentation Training, slides # 12, 14, 16, & 34.)
    a. Noted slides address the requirement to demonstrate beneficiary participation and agreement with the plan.
2. PNP CA64 delineates requirements to demonstrate evidence of beneficiary's participation and agreement with client plan, unless refusal is documented. (See Attachment: Section K CA-64: Client Plan/Individual Services and Supports Plan)
    a. All new VCBH and Contracted staff will be required to train on this policy during initial orientation (Projected 12/31/18).
3. Avatar reports are emailed weekly to clinic administrators to track treatment plans that are missing client/guardian signature. (See Attachment: Section K Client ISSP Signature Exceptions 5792).
4. A new protocol has been put in place requiring providers to amend progress notes documenting treatment planning outreach attempts with dates of subsequent progress notes referencing ongoing outreach attempts. This will help track the timeline of outreach efforts to engage clients in treatment planning.
5. A comprehensive Clinical Documentation Training and users' manual is being developed to augment the already-established clinical documentation training (projected 12/31/18).
    a. All new and existing staff will then be required to participate in this revised training, followed by annual boosters to focus on identified documentation deficiencies.
    b. Training will specifically reinforce initial and ongoing protocols to ensure treatment plan participation and agreement
6. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
    a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
        i. QR reviews will identify and disallow unauthorized services
    b. Disallowance Dashboard management tool has been developed to identify disallowed units due to missing authorized treatment plans per specific programs/staff (See Attachment: Section K VCBH MH Disallowance DASHBOARD)
    c. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues

Progress Notes

PROTOCOL REQUIREMENT:

5a. Do the progress notes document the following:

1) Timely documentation (as determined by the MHP) of relevant aspects of client care, including documentation of medical necessity?

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

3) Interventions applied, beneficiary's response to the interventions, and the location of the interventions?

4) The date the services were provided?

2) Documentation of referrals to community resources and other agencies, when appropriate?

3) Documentation of follow-up care or, as appropriate, a discharge summary?

4) The amount of time taken to provide services?

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

• CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c) • CCR, title 9, chapter 11, section 1840.112(b)(2-6) • CCR title 9, chapter 11, section 1840.314 • CCR, title 9, chapter 11, sections 1840.316 - 1840.322 • CCR, title 22, chapter 3, section 51458.1 • CCR, title 22, chapter 3, section 51470 • MHP Contract, Exhibit A. Attachment I

FINDING 5a:

Progress notes were not completed in accordance with regulatory and contractual requirements and/or with the MHP's own written documentation standards:

- One or more progress note was not completed within the timeliness and frequency standards in accordance with regulatory and contractual requirements.
- Progress notes did not document the following:

5a-1) Line numbers [redacted]: Timely documentation of relevant aspects of beneficiary care as specified by the MHP's documentation standards (i.e., progress notes completed late based on the MHP's written documentation standards in effect during the audit period). Professional degree.

Appointment was missed or cancelled: Line numbers [redacted]. RR19a, refer to
Recoupment Summary for details.

PLAN OF CORRECTION:

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

1) Describe how the MHP will ensure that progress notes are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.
2) The MHP shall submit a POC that indicates how the MHP will ensure that progress notes document:

5a-1) Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and the MHP's written documentation standards.

5a-8) The provider's/providers' professional degree, licensure or job title.

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

VCBH Plan of Correction K5a1, 5a8:

1. Currently, all new and targeted existing staff participate in Clinical Documentation Training. (See Attachment: Section K Clinical Documentation Training, slides # 7, 38, 41, 42, 43 & 57.)
    a. Noted slides address progress notes timeline requirements, scope of practices guidelines, and progress note components required to substantiate qualifying diagnosis and address identified impairments.
2. A comprehensive Clinical Documentation Training and users' manual is being developed to augment the already-established clinical documentation training (projected 12/31/18).
    a. All new and existing staff will then be required to participate in this revised training, followed by annual boosters to focus on identified documentation deficiencies.
    b. Training will specifically reinforce progress note required elements and timelines.
3. When progress notes created on the electronic medical record are finalized and submitted, the provider's professional degree, licensure or job title are populated onto the note. (See Attachment: Section K Progress Note Sample with Staff Discipline)
4. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
    a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
        i. QR reviews will identify and disallow unauthorized services
    b. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues

FINDING 5a3:

The progress note for the following Line number indicate that the service provided was solely:

- Clerical: Line number ■ RR17, refer to Recoupment Summary for details.

PLAN OF CORRECTION:

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

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

2) Services provided and claimed are not solely clerical related.

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

VCBH Plan of Correction K5a3:

1. Currently, all new and targeted existing staff participate in Clinical Documentation Training. (See Attachment: Section K Clinical Documentation Training, slides # 38, 39, 40 & 60)
    a. Noted slides address what interventions constitute billable services, and which services, such as clerical tasks are never-billable.
2. A comprehensive Clinical Documentation Training and users' manual is being developed to augment the already-established clinical documentation training (projected 12/31/18).
    a. All new and existing staff will then be required to participate in this revised training, followed by annual boosters to focus on identified documentation deficiencies.
    b. Training will specifically reinforce the requirement for progress notes to document services that reduce impairment, restore functioning, or prevent significant deterioration as outlined in the client plan.
3. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
    a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
        i. QR reviews will identify and disallow unauthorized services
    b. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues

PROTOCOL REQUIREMENT:

5b. When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include:

1) Documentation of each person's involvement in the context of the mental health needs of the beneficiary?
2) The exact number of minutes used by persons providing the service?
3) 3) Signature(s) of person(s) providing the services?

• CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c) • CCR, title 9, chapter 11, section 1840.112(b)(2-6) • CCR title 9, chapter 11, section 1840.314 • CCR, title 9, chapter 11, sections 1840.316 - • CCR, title 22, chapter 3,section 51458.1 • CCR, title 22, chapter 3, section 51470 • MHP Contract, Exhibit A, Attachment I

FINDING 5b:

Documentation of services being provided to, or on behalf of, a beneficiary by two or more

persons at one point in time did not include all required components. Specifically:

- Line numbers [redacted]: Progress notes did not document the contribution, involvement or participation of each staff member as it relates to the identified functional impairment and mental health needs of the beneficiary.

- The following Line number had claims for which the time claimed was greater than the time documented on the corresponding progress notes: Line number [redacted].
  RR10, refer to Recoupment Summary for details.

PLAN OF CORRECTION 5b:

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

1) Group progress notes clearly document the contribution, involvement or participation of each staff member as it relates to the identified functional impairment and mental health needs of the beneficiary.
2) There is medical necessity for the use of multiple staff in the group setting.
3) The MHP shall submit a POC that indicates how the MHP will ensure that the type of service, units of time and dates of service (DOS) claimed are accurate and consistent with the documentation in the medical record and that services are not claimed when billing criteria are not met.

VCBH Plan of Correction K5b:

1. Currently, all new and targeted existing staff participate in Clinical Documentation Training. (See Attachment: Section K Clinical Documentation Training, slides # 58 & 70.)
    a. Noted slides address use of formula to calculate billable group therapy minutes.
2. A comprehensive Clinical Documentation Training and users' manual is being developed to augment the already-established clinical documentation training (projected 12/31/18).
    a. All new and existing staff will then be required to participate in this revised training, followed by annual boosters to focus on identified documentation deficiencies.
    b. Training will specifically reinforce the requirement to document the medical necessity and specific roles of multiple staff group leaders.
3. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
    a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
        i. QR reviews will identify and disallow unauthorized services
    b. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues

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PROTOCOL REQUIREMENT:

5c. Timeliness/frequency as follows:

1) Every service contact for:

A. Mental health services

B. Medication support services

C. Crisis intervention

D. Targeted Case Management

2) Daily for:

A. Crisis residential

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

C. Day treatment intensive

3) Weekly for:

A. Day treatment intensive (clinical summary)

B. Day rehabilitation

C. Adult residential

• CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c) • CCR, title 9, chapter 11, section 1840.112(b)(2-6) • CCR title 9 chapter 11 section 1840.314 • CCR, title 9, chapter 11, sections 1840.316 - 1840.322 • CCR, title 22, chapter 3, section 51458. 1 • CCR, title 22, chapter 3, section 51470 • MHP Contract, Exhibit A, Attachment I

FINDING 5c:

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

- Line number [redacted]: There was no progress note in the medical record for the services claimed. RR9, refer to Recoupment Summary for details.

  During the review, the MHP staff was given the opportunity to locate the documents in question but could not find written evidence of them in the medical record.

- Line numbers [redacted]: The type of specialty mental health service (SMHS) documented on the progress note was not the same type of SMHS claimed. RR9, refer to Recoupment Summary for details.

PLAN OF CORRECTION 5c:
The MHP shall submit a POC that indicates how the MHP will:

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1) Ensure that all SMHS claimed are:
   a) Documented in the medical record.
   b) Actually provided to the beneficiary.
   c) Claimed for the correct service modality and billing code.
2) Ensure that all progress notes are:
   a) Accurate and meet the documentation requirements described in the MHP Contract with the Department.
   b) Indicate the type of service, the date the service was provided and the amount of time taken to provide the service as specified in the MHP Contract with the Department.
   c) Completed within the timeline and frequency specified in the MHP Contract with the Department.
   d) Legible in order to determine that the claimed mental health services were actually provided.

VCBH Plan of Correction K5c:

1. Currently, all new and targeted existing staff participate in Clinical Documentation Training. (See Attachment: Section K Clinical Documentation Training, slides # 39 - 44, 59 & 60.)
    a. Noted slides address requirements that all SMHS claims are to be documented, demonstrate services provided utilizing correct modality and billing codes, accurate, indicate type and date of service, completed within timeline and specified frequency and are legible.
2. A comprehensive Clinical Documentation Training and users' manual is being developed to augment the already-established clinical documentation training (projected 12/31/18).
    a. All new and existing staff will then be required to participate in this revised training, followed by annual boosters to focus on identified documentation deficiencies.
    b. Training will specifically reinforce the above-stated requirements for documenting provision of SMHS.
3. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
    a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
        i. QR reviews will identify and disallow unauthorized services
    b. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues

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PROTOCOL REQUIREMENT:

5d. Do all entries in the beneficiary's medical record include:

1) The date of service?

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

3) The date the documentation was entered in the medical record?

• CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c) • CCR, title 9, chapter 11, section 1840.112(b)(2-6) • CCR, title 9. chapter 11 section 1840.314 • CCR, title 9, chapter 11, sections 1840.316 - • CCR, title 22, chapter 3, section 51458.1 • CCR, title 22, chapter 3, section 51470 • MHP Contract. Exhibit A, Attachment I

FINDING 5d:

The Progress note did not include:

- The signature of the person providing the service (or electronic equivalent) as specified in the MHP Contract with the Department: Line number [redacted]. RR15, refer to Recoupment Summary for details.
- The provider's professional degree, licensure, or job title: Line number [redacted].

PLAN OF CORRECTION 5d:
The MHP shall submit a POC that indicates how the MHP will ensure that all documentation includes the signature or (electronic equivalent) with the professional degree, licensure or title of the person providing the service.

VCBH Plan of Correction K5d:

1. Currently, all new and targeted existing staff participate in Clinical Documentation Training. (See Attachment: Section K Clinical Documentation Training, slides # 39, 43, 44, 57, 59, & 60.)
    a. Noted slides address requirements for all documentation to include signatures with professional degree, licensure or title of person providing the service.
2. A comprehensive Clinical Documentation Training and users' manual is being developed to augment the already-established clinical documentation training (projected 12/31/18).
    a. All new and existing staff will then be required to participate in this revised training, followed by annual boosters to focus on identified documentation deficiencies.
    b. Training will specifically reinforce the documentation signature requirements.
3. When progress notes created on the electronic medical record are finalized and submitted, the provider's professional degree, licensure or job title are populated onto the note. (See Attachment: Section K Progress Note Sample with Staff Discipline)

4. Utilization Review (See Attachment: Section K UR-01 - UR for Outpatient MH Services Clinics; See Attachment: Section K UR 02 - UR for VCBH Contractors)
    a. Utilization Review / Chart Review: Adherence to policy and regulatory requirements are monitored through monthly utilization review audits
        i. QR reviews will identify and disallow unauthorized services
    b. Quarterly meetings with UR/Clinic Administrators to identify common errors/training issues