FISCAL YEAR (FY) 2016/2017 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
SUTTER-YUBA COUNTY MENTAL HEALTH PLAN REVIEW
October 3-6, 2016
FINDINGS REPORT

This report details the findings from the triennial system review of the Sutter-Yuba County Mental Health Plan (MHP). The report is organized according to the findings from each section of the FY 2016/2017 Annual Review Protocol for Consolidated Specialty Mental Health Services (SMHS) and Other Funded Services (Mental Health and Substance Use Disorder Services Information Notice No.16-045), specifically Sections A-J and the Attestation. This report details the requirements deemed out of compliance (OOC), or in partial compliance, with regulations and/or the terms of the contract between the MHP and DHCS. The corresponding protocol language, as well as the regulatory and/or contractual authority, will be followed by the specific findings and required Plan of Correction (POC).

For informational purposes, the findings report also includes additional information that may be useful for the MHP, including a description of calls testing compliance of the MHP's 24/7 toll-free telephone access line and a section detailing information gathered for the 14 "SURVEY ONLY" questions in the protocol.

The MHP will have an opportunity to review the report for accuracy and appeal any of the findings of non-compliance (for both System Review and Chart Review). The appeal must be submitted to DHCS in writing within 15 business days of receipt of the findings report. DHCS will adjudicate any appeals and/or technical corrections (e.g., calculation errors, etc.) submitted by the MHP prior to issuing the final report.

A Plan of Correction (POC) is required for all items determined to be out of compliance. The MHP is required to submit a POC to DHCS within 60 days of receipt of the findings report for all system and chart review items deemed out of compliance. The POC should include the following information:

(1) Description of corrective actions, including milestones
(2) Timeline for implementation and/or completion of corrective actions
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS
(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should purpose an alternative corrective action plan to DHCS
(5) Description of corrective actions required of the MHP's contracted providers to address findings

Report Contents

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	16		100%
SECTION B: ACCESS	48	0	3	48	10b1, 10b2, 10b3	94%
SECTION C: AUTHORIZATION	26	2	2	28	6a1, 6c	92%
SECTION D: BENEFICIARY PROTECTION	25	0	0	25		100%
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	0	6		100%
SECTION H: PROGRAM INTEGRITY	19	4	1	22	H4a	95%
SECTION I: QUALITY IMPROVEMENT	33	6	0	39		100%
SECTION J: MENTAL HEALTH SERVICES ACT	21	0	0	21		100%
TOTAL ITEMS REVIEWED	**203**	**14**	**6**			

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	6		**OUT OF 200**	
OVERALL PERCENTAGE OF COMPLIANCE	**IN**		**OOC/Partial**	
	(# IN/200)	97%	(# OOC/200)	3%

FINDINGS

ATTESTATION

DHCS randomly selected five Attestation items to verify compliance with regulatory and/or contractual requirements. All requirements were deemed in compliance. A Plan of Correction is not required.

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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*

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

Test Call #1 was placed on September 9, 2016 at 9:15 a.m. The call was answered after one (1) ring by a live operator. The DHCS test caller requested information about filing a complaint and the operator advised the caller of the beneficiary problem resolution process. The operator asked for the caller's name and the nature of the complaint. The caller provided name and declined to furnish the nature of the complaint. The caller stated that he/she could come into MHP to complete the complaint form and speak to someone if desired. The operator provided the address and hours of operation of a local MHP clinic. The caller was provided with information about how to use the beneficiary problem resolution process. The call was deemed in compliance with the regulatory requirements for protocol question B9a4.

Test Call #2 was placed on September 14, 2016 at 7:30 a.m. The call was answered after one (1) ring by a live operator. The DHCS test caller requested information about mental health services. The operator asked the caller for his/her name which the caller provided. The operator asked the caller if he/she needed immediate services and inquired if he/she had

suicidal thoughts or thoughts of hurting self and/or someone else. The caller responded in the negative. The operator explained the process for accessing SMHS including the availability of walk-in services. The caller was provided the location and hours of operation of the MHP. For immediate services, the operator informed the caller that he/she could again contact the 24/7 crisis line. The caller was provided information about how to access SMHS including SMHS required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition. The call was deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #3 was placed on September 16, 2016, at 7:50 a.m. The call was initially answered after one (1) ring by a live operator. The DHCS test caller requested information about how to access mental health services. The operator advised the caller of the process regarding walk-in services including location and hours of operation. However, after hearing the caller was requesting services for a child, the caller was placed on hold briefly and transferred to another operator. The second operator provided information about how to access MH for a child in addition to information about services needed to treat a beneficiary's urgent condition. The call was deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #4 was placed on September 7, 2016 at 4:17 p.m. The test call was answered after three (3) rings by a live operator. The DHCS test caller requested information about filing a complaint. The operator provided information regarding how to use the beneficiary problem resolution and state fair hearing processes. The operator informed the caller he/she could access the complaint forms in the lobby of the MHP and provided the clinic location and hours of operation. The caller was also informed how to file a complaint after business hours. The caller was provided information about how to use the beneficiary problem resolution process. The call was deemed in compliance with the regulatory requirements for protocol question B9a4.

Test Call #5 was placed on September 15, 2016, at 11:11 p.m. The call was initially answered after one (1) ring by a live operator. The DHCS test caller requested information about how to access mental health services. The operator requested the caller's age and then transferred the caller to a crisis operator. The operator answered the call immediately and asked questions to assess the caller's current condition. The caller then repeated the request for information about accessing services. The operator asked the caller for insurance information and the caller responded he/she has Medi-Cal. The operator advised the caller of the walk-in assessment process and provided the clinic address, alternate phone numbers, and hours of operation. The operator advised the caller the access line was available 24 hours a day/7 days a week. The caller was provided with information about how to access SMHS including SMHS required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition. The call was deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

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Test Call #6 was placed on September 16, 2016, at 10:54 a.m. The call was initially answered after one (1) ring by a live operator. The DHCS test caller requested information about mental health services. The operator asked the caller if he/she was calling about a mental health assessment and the caller responded in the negative. The operator transferred

the call to an operator and after a brief hold the operator was on the line to assist the caller. The caller repeated the request for services. The operator asked the caller if he/she had previously been seen at the MHP and the caller responded in the negative. The operator explained the process for accessing SMHS including the availability of walk-in services. The operator provided the clinic location and hours of operation. The operator asked the caller for insurance type and date of birth and the caller provided the information. The caller was provided information about how to access SMHS including SMHS required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition. The call was deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #7 was placed on September 15, 2016, at 3:01 p.m. The call was initially answered after two (2) rings by a live operator. The DHCS test caller requested information about mental health services. The operator asked if the caller had Medi-Cal. The caller replied in the affirmative and that he/she was in the process of transferring Medi-Cal to the county. The operator advised the caller of the walk-in and assessment processes including location and hours of operation. The caller was provided information about how to access SMHS including SMHS required to assess whether medical necessity criteria are met. The call was deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

FINDINGS

Test Call Results Summary

Protocol Question	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
B9a1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**Not Rated**
B9a2	N/A	IN	IN	N/A	IN	IN	IN	**100%**
B9a3	N/A	IN	IN	N/A	IN	IN	IN	**100%**
B9a4	IN	N/A	N/A	IN	N/A	N/A	N/A	**100%**

PLAN OF CORRECTION:

All requirements were deemed in compliance. A POC is not required.

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 log(s) of initial requests for SMHS include requests made by phone, in person, or in writing. There is insufficient evidence the MHP consistently logs all requests made for SMHS by beneficiaries. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Outpatient Services Access Log. The log(s) made available by the MHP did not include the required elements for all DHCS test calls. The table below details the findings:

Date of Call	Time of Call	Log Results		
		Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
9/14/16	7:30a.m.	IN	IN	IN
9/16/16	7:50a.m.	OUT	OUT	OUT
9/15/16	11:11p.m.	IN	IN	IN
9/16/16	10:54a.m.	OUT	OUT	OUT
9/15/16	3:01p.m.	OUT	OUT	OUT
Compliance Percentage		**40%**	**40%**	**40%**

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

Protocol question(s) 10b1, 10b2, and 10b3 are deemed in partial compliance.

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SECTION C: AUTHORIZATION

PROTOCOL REQUIREMENTS	
C6.	Regarding Notices of Action (NOAs):
C6a.	1) NOA-A: Is the MHP providing a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible to any SMHS?
	2) Does the MHP provide for a second opinion from a qualified health care professional within the MHP network or arrange for the beneficiary to obtain a second opinion outside the MHP network, at no cost to the beneficiary?
• *CFR, title 42, sections 438.10(c), 438.400(b) and 438.404(c)(2)* • *CCR, title 9, chapter 11, sections 1830.205(a), (b)(1), (2), (3), 1850.210 (a)-(j) and 1850.212* • *DMH Letter No. 05-03*	• *MHP Contract, Exhibit A, Attachment I* • *CFR, title 42, section 438.206(b)(3)* • *CCR, title 9, chapter 11, section 1810.405(e)*

FINDINGS

The MHP did not furnish evidence it provides a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible for any SMHS. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: P&P #09-003 Notices of Action, Access to Services

Report, and a sample of 13 NOA-As. The MHP's policy specifies a procedure in accordance with state and federal requirements. However, the MHP's P&P does not adequately address the MHP's efforts to monitor provider compliance with the NOA requirements. The MHP's access to services report details the benefit determinations for all beneficiary receiving a MH assessment during the period specified in the sample. DHCS identified one beneficiary in the sample who was not issued a NOA-A as required. Protocol question(s) C6a1 is deemed in partial compliance.

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 provides a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible for any SMHS.

PROTOCOL REQUIREMENTS	
C6c.	NOA-C: Is the MHP providing a written NOA-C to the beneficiary when the MHP denies payment authorization of a service that has already been delivered to the beneficiary as a result of a retrospective payment determination?
• *CFR, title 42, sections 438.10(c), 438.400(b) and 438.404(c)(2)* • *CCR, title 9, chapter 11, sections 1830.205(a), (b)(1), (2), (3), 1850.210 (a)-(j) and 1850.212* • *DMH Letter No. 05-03* • *MHP Contract, Exhibit A, Attachment I* • *CFR, title 42, section 438.206(b)(3)* • *CCR, title 9, chapter 11, section 1810.405(e)*	

FINDING

The MHP did not furnish evidence it provides a written NOA-C to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible for any SMHS. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: P&P #09-003 Notices of Action, Access to Services Report, and a sample of 9 NOA-Cs. Protocol question(s) C6c is deemed in partial compliance. The MHP's policy specifies a procedure in accordance with state and federal requirements. The MHP's access to services report details the benefit determinations for all beneficiaries receiving a MH assessment during the period specified in the sample. DHCS identified one beneficiary in the sample who was not issued a NOA-C as required. In addition, the MHP's P&P does not adequately address the MHP's efforts to monitor provider compliance with the NOA requirements. Protocol question C6c 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-C to the beneficiary when the MHP denies payment authorization of a service that has already been delivered to the beneficiary as a result of a retrospective payment determination.

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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?
• *CFR, title 42, sections 455.101 and 455.104*	• *MHP Contract, Exhibit A, Attachment I, 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 employees complete Form 700 per county policy. DHCS reviewed the additional documentation presented by the MHP as evidence of compliance for contract providers: Provider contracts for Family Life Center, 7th Ave Center and Victor Community Support Services. DHCS also reviewed an email sent by the MHP's QI staff to Victor (VCSS). In the email, the MHP requested disclosure information from the contractor; however, the contractor did not submit documentation citing lack of ownership due to its 501(C)3 status. The federal requirements refer to ownership and control information and is, applicable to 501(C)3 organizations. While the MHP made an attempt to collect the required information, it was not successful. Protocol question H4a 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 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. In addition, it is recommended that the MHP add language to provider contracts to include part 455 survey requirements.

SURVEY ONLY FINDINGS

SECTION A: Network Adequacy and Array of Services

PROTOCOL REQUIREMENTS	
A4b.	**SURVEY ONLY:** Does the MHP maintain and monitor an appropriate network of providers to meet the anticipated need of children/youth eligible for ICC and IHBS services?
• *Katie A Settlement Agreement* • *Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care for Katie A Subclass Members*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Victor Community Support Services Provider Contract and P&P #11-027 Katie A. The MHP's Youth and Family Services staff use the practices and principles of the Core Practice Model (CPM) approach when working with children and families involved with child welfare and behavioral health, which requires collaboration between child welfare staff, mental health staff, service providers and community partners working with the children/youth and families. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

PROTOCOL REQUIREMENTS	
A4d.	**SURVEY ONLY:** Does the MHP have a mechanism to ensure all children/youth referred and/or screened by the MHP's county partners (i.e., child welfare) receive an assessment, and/or referral to a MCP for non-specialty mental health services, by a licensed mental health professional or other professional designated by the MHP?
• *Katie A Settlement Agreement* • *Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care for Katie A Subclass Members*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: P& P #11-027 Katie A, #11-021 Youth Service Triage Screening Process, #12-035 ICC & IHBS, FAST Referral Case Summary, and YCAT Referral Case Summary. The MHP's policy states that all children/youth with an open child welfare case who are referred to behavioral health,

receive an assessment and/or referral to a Managed Care Plan. All children/youth that become part of an open child welfare services case will be screened for mental health needs during the intake process. The mental health screening, once completed, is given to the Youth Open Access Clinic. Based on the information gathered, a child/youth may be referred for a mental health assessment and subsequent services. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

SECTION C: Authorization

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),* • *WIC 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: P& P #12-010 Authorization for Out of Plan Services and #12-009 M/C Beneficiary Requesting Services Out of County. The documentation lacks specific elements to demonstrate compliance with federal and State requirements. Specifically, the MHP's current policy states once the Quality Assurance Program (QAP) receives the Standard/Service Authorization Request (SAR) from the host county, a licensed staff member will review the information, and will approve, deny or modify it and will fax it to the host county within three (3) working days. The MHP's procedure is consistent with the existing state policy. However, AB1299 establishes new requirements for presumptive transfer.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Revise its P&P to reflect new state requirements for AB 1299 and to ensure its authorization and provision of SMHS for a child who will be placed out of county is transferred within 48 hours.

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),* • *WIC 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: P&P #12-010 Authorization for Out of Plan Services and #12-009 M/C Beneficiary Requesting Services Out of County. The documentation lacks specific elements to demonstrate compliance with federal and State requirements. Specifically, the MHP did not provide a policy or procedure that states an assessment is conducted and authorization of services occurs within 4 business days of receipt of a referral for SMHS for a child by another MHP.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Develop a policy and procedure that ensures an assessment is conducted and authorization of services occurs within 4 business days of receipt of referral for SMHS for a child by another MHP.

SECTION H: Program Integrity

PROTOCOL REQUIREMENTS	
H4b.	**SURVEY ONLY:** Does the MHP require its 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: Provider Contracts for Family Life Center, 7th Ave Center, and Victor Community Support Services. The documentation lacks specific elements to demonstrate compliance with federal and State requirements. Specifically, the provider contracts do not include language described in 42 CFR 455.434(a) which states, as a condition of enrollment, they must require

providers to consent to criminal background checks including fingerprinting when required to do so under State law or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider. In addition, the MHP did not provide any other documentation.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Suggest adding language to provider contracts that states, as a condition of enrollment, they must require providers to consent to criminal background checks including fingerprinting when required to do so under State law or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider. In addition, develop P&P and a method for monitoring compliance with 42 CFR 455.434(a).

PROTOCOL REQUIREMENTS	
H4c.	**SURVEY ONLY:** Does the MHP require 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: Provider Contracts for Family Life Center, 7th Ave Center, and Victor Community Support Services. The documentation lacks specific elements to demonstrate compliance with federal and State requirements. Specifically, the provider contracts do not include language described in 455.434 (b)(1) that states, upon the State Medicaid agency determining that a provider, or a person with a 5 percent or more direct or indirect ownership interest in the provider, meets the State Medicaid agency's criteria hereunder for criminal background checks as a “high” risk to the Medicaid program, the State Medicaid agency will require that each such provider or person submit fingerprints. In addition, the MHP did not provide any other documentation.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Suggest adding language to provider contracts that states, upon the State Medicaid agency determining that a provider, or a person with a 5 percent or more direct or indirect ownership interest in the provider, meets the State Medicaid agency's criteria hereunder for criminal background checks as a “high” risk to the Medicaid program, the State Medicaid agency will require that each such provider or person submit fingerprints. In addition, develop P&P and method for monitoring compliance with 42 CFR 455.434(b)(1).

PROTOCOL REQUIREMENTS	
H7.	**SURVEY ONLY:** Does the MHP verify that all ordering, rendering, and referring providers have a current National Provider Identifier (NPI) number?
CFR, title 42, sections 455.410, 455.412 and 455.440	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: P&P #02-043 Screening of Employee Licenses and Exclusionary Checks. The MHP's policy states the National Plan and Provider Enumeration System will also be checked to determine if an individual has a current NPI number. If not, the individual will be assisted in obtaining an NPI upon hire. The documentation provides sufficient evidence of compliance with federal and state requirements.

SUGGESTED ACTIONS

No further action required at this time.

SECTION I: QUALITY IMPROVEMENT

PROTOCOL REQUIREMENTS	
I3b.	**SURVEY ONLY:** Does the MHP have a policy and procedure in place regarding monitoring of psychotropic medication use, including monitoring psychotropic medication use for children/youth?
CFR, title 42, sections 455.410, 455.412 and 455.440	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: P & P #15-003 Medication Monitoring Plan, and #05-002 Monitoring Annual QI Indicators. The documentation lacks specific elements to demonstrate compliance with federal and State requirements. The MHP conducts routine sampling for purposes of monitoring psychotropic medication use. However, the sample does not include contracted or out of county providers.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Expanding the sample size to include contracted and out of county providers.

PROTOCOL REQUIREMENTS	
I3c.	**SURVEY ONLY:** If a quality of care concern or an outlier is identified related to psychotropic medication use is there evidence that the MHP took appropriate action to address the concern?
• *CFR, title 42, sections 455.410, 455.412 and 455.440*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: P&P #15-003 and Medication Monitoring Committee Annual Report. The MHP policy states its medication monitoring process will contribute to total quality improvement of client medication use, by ensuring peer review, and by fostering consultation among psychiatrists for confirmation of decisions in cases of uncertain or questionable medication prescribing. In addition, the MHP's Medication Monitoring Committee meets monthly to review charts/cases for the purpose of assuring medications and prescriptions are provided appropriately, safely, and effectively. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

PROTOCOL REQUIREMENTS	
I10. I10a.	Regarding the adoption of practice guidelines: **SURVEY ONLY** Does the MHP have practice guidelines, which meet the requirements of the MHP contract, in compliance with 42 CFR 438.236 and CCR title 9, section 1810.326 ?
I10b.	**SURVEY ONLY** Does the MHP disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries?
I10c.	**SURVEY ONLY** Does the MHP take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other areas to which the guidelines apply are consistent with the guidelines adopted?
• *MHP Contract, Exhibit A, Attachment I* • *42 CFR 438.236*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: P&P #09-009 Practice Guidelines, #08-023 Suicide Risk Assessment Protocol, and #17-001 Clozaril Clinic Operating Protocol. The MHP indicated it is in the process of developing

additional practice guidelines. However, the documentation lacks specific elements to demonstrate compliance with federal and state requirements. Specifically, the MHP does not have a documented process for disseminating its practice guidelines to beneficiaries and its contracted providers.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: develop a process that ensures practice guidelines are developed in accordance with state and federal requirements and disseminated to beneficiaries and contracted providers.