FISCAL YEAR (FY) 2016/2017 ANNUAL REVIEW OF SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
SAN BENITO COUNTY MENTAL HEALTH PLAN REVIEW
May 15 -18, 2017
FINDINGS REPORT AMENDED

This report details the findings from the triennial system review of the **San Benito 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, this 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 16 "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 Findings Report
San Benito County Mental Health Plan
Fiscal Year 2016/2017

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	1/5	6	80%
SECTION A: NETWORK ADEQUACY AND ARRAY OF SERVICES	14	2	0/14		100%
SECTION B: ACCESS	48	0	4/48	2c, 10b1,10b2,10b3,	92%
SECTION C: AUTHORIZATION	26	2	2/26	1c,6c	93%
SECTION D: BENEFICIARY PROTECTION	25	0	1/25	6	96%
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	0/19		100%
SECTION I: QUALITY IMPROVEMENT	30	8	0/30		100%
SECTION J: MENTAL HEALTH SERVICES ACT	21	0	0/21		100%
TOTAL ITEMS REVIEWED	**200**	**16**	**8**		

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	**8**		**OUT OF 200**	
OVERALL PERCENTAGE OF COMPLIANCE	**IN** (# IN/200)	96%	**OOC/Partial** (# OOC/200)	4%

FINDINGS

ATTESTATION

DHCS randomly selected five Attestation items to verify compliance with regulatory and/or contractual requirements. Below is a summary of findings for requirements deemed out-of-compliance.

ATTESTATION REQUIREMENTS	
6.	The MHP must maintain written policies and procedures that provides for the education of staff and the MHP's network providers concerning its policies and procedures (P&Ps) on advance directives.
• *CFR, title 42, sections 438.3(j); 422.128(b)(1)(ii)(H) and 417.436(d)(1)(vi)*	

FINDING

The MHP did not furnish evidence it maintains written policies and procedures that provides for the education of staff and the MHP's network providers concerning its policies and procedures (P&Ps) on advance directives. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: P&P CLN 03:11 Advance Health Care Directives. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the policy did not address how the MHP provides for the education of staff and network providers regarding advance directives and there was no evidence of education provided, for example: an employee orientation schedule that shows that the Advance Directive Policy is on the schedule; sign-in sheets with dates and staff signatures indicating attendance at new employee orientation; signed acknowledgements by staff indicating that they have read and understand their responsibilities related to advance directives. This Attestation requirement 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 maintains written policies and procedures that provides for the education of staff and the MHP's network providers concerning its policies and procedures (P&Ps) on advance directives.

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SECTION B: ACCESS

PROTOCOL REQUIREMENTS	
B2c.	Regarding the provider list, does it contain the following:
	1. Names of Providers?
	2. Locations?
	3. Telephone numbers?
	4. Alternatives and options for linguistic services including non-English languages (including ASL) spoken by providers?
	5. Does the list show providers by category?
	6. Alternatives and options for cultural services?
	7. A means to inform beneficiaries of providers that are not accepting new beneficiaries?
• *CFR, title 42, section 438.10(f)(6)(i)and 438.206(a)* • *CCR, title 9, chapter 11, section 1810.410* • *CMS/DHCS, section 1915(b) Waiver*	• *DMH Information Notice Nos. 10-02 and 10-17* • *MHP Contract Exhibit A, Attachment I*

FINDINGS

The MHP did not furnish evidence its provider list contains all of the required components. DHCS reviewed the MHP's current provider list. However, the list did not include the following components: Alternatives and options for cultural services. Specifically, the Provider List did not provide alternatives and options for cultural services for Lesbian, Gay, Bisexual and Transgender or Questioning (LGBTQ) beneficiaries. Protocol question(s) B2c6 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 its provider list contains all of the required components, specifically

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 April 10, 2017 at 8:39 p.m. The call was answered after two (2) rings via a live operator. The caller requested information about accessing SMHS in the county. The operator suggested having a counselor call the caller in the morning. The caller declined the opportunity of receiving a call from a counselor. The operator verified the caller's insurance (Medi-Cal) and requested the caller's address of residence. The operator advised the caller of the availability of walk-in services. The operator provided the address and hours of operation of a clinic near the caller's residence. The operator asked about the caller's current condition. The caller assured the operator that immediate services were not required at this time. The operator informed the caller of the availability of the 24/7 access line. The operator did a final crisis check and offered the caller warm words of encouragement. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #2 was placed on April 13, 2017, at 7:36 a.m. and answered after one (1) ring via a live operator. The caller requested information about accessing mental health services in the county. The operator offered to have staff return the call after 8 a.m. or that the caller could call back after 8 a.m. When prompted, the operator provided the phone number, address, and hours of operation for a walk-in clinic and suggested documents the caller should bring to an assessment. For urgent services, the operator suggested the caller could go to the hospital, call the crisis line, or go the clinic if needed. The operator asked the caller if he/she was having thoughts of hurting him/herself or taking his/her life. The caller replied in the negative. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #3 was placed on April 10, 2017, at 2:40 p.m. The call was answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county for the caller's son. The operator asked if the child needed urgent care. The caller replied in the negative. The operator asked the caller to provide his/her name and contact information in case the call got disconnected. The operator explained the intake process. The operator advised the caller that someone from the county would contact the caller later in the week to schedule an assessment. The operator also provide the address, hours of operation, and phone number to the clinic. The caller was provided information about how to access SMHS including SMHS required to assess whether medical necessity criteria are met and about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #4 was placed on March 16, 2017, at 1:56 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about accessing mental health services in the county for depression. The operator asked if the caller wanted to hurt him/herself or others and needed to speak to someone immediately. The caller replied in the negative. The operator asked if this was the caller's first time calling the clinic. The caller replied in the affirmative. The operator explained the intake process (30 minutes for clerical/registration and 2 hours for assessment with a clinician). The operator offered to schedule an appointment if the caller was a San Benito County resident. The caller answered yes to residency. The operator provided the address and hours/days of operation and the callback number for after hours. The operator explained to the caller that he/she could call back and ask to speak with a Crisis Worker if needed during business hours and after hours. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, the caller provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #5 was placed on April 13, 2017, at 7:39 a.m. The call was answered after one (1) ring via a live operator. The operator identified him/herself. The caller requested information about filling a complaint against his/her therapist. The operator asked the caller's name. The caller provided his/her name. The operator stated that he/she needed to get some additional information and that the caller had reached the afterhours line and he/she would need to fax the information over to the daytime staff. The operator explained that the county has a formal

grievance process and the Quality Improvement team would receive the information and be returning the call to the caller. The operator stated that there are grievance forms in the lobby of the clinic and offered to provide the address and hours of operation. The operator asked for the caller's full name, DOB, and a call back number. The caller provided his/her name, DOB, but stated that he/she was using a friend's phone and preferred not to provide the number. The operator requested the caller's number again. The caller repeated his/her preference not to provide the number. The operator stated that that was fine and the caller could call back once the office is open, which would be in about 15 minutes. He/she also stated that since the caller had reached the crisis line he/she wanted to know if the caller had any thoughts about hurting himself/herself or others. The caller replied in the negative. The operator then stated that he/she would also like to provide the office address because there are forms available at the clinic location. She provided 1131 San Felipe Road Hollister 95023 and operating hours from 8-5 and stated that the grievance forms are available if the caller wanted to get the form there. The caller was provided information about how to about how to use the beneficiary problem resolution and information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions B9a3 and B9a4.

Test Call #6 was placed on April 24, 2017, at 7:37 a.m. The call was answered immediately via a live operator. The caller requested information about how to file a complaint. The operator informed the caller that he/she can walk in to file a grievance and the grievance form is located in the lobby or the caller can call in during business hours and talk to a quality improvement staff. The operator provided the address and business hours. The operator asked the caller's telephone number to have a quality improvement staff call the caller back. The caller informed the operator that he/she would like to file the complaint anonymously. The caller thanked the operator and ceased the call. The caller was provided information about how to use a beneficiary problem resolution and fair hearing processes. The call is deemed In Compliance with the regulatory requirements for protocol question B9a4.

Test Call #7 was placed on April 26, 2017, at 8:42 a.m. The call was answered after one (1) ring via live operator. The operator asked the caller's name. The caller provided his/her name and explained to the operator that he/she had just moved to Hollister, was running out of his/her anxiety medication, and was calling to obtain some information regarding how and where he/she could get his/her prescription filled. The operator asked if caller had Medi-Cal. The caller replied in the affirmative. The operator asked caller if he/she had transferred his/her Medi-Cal to San Benito County. The caller replied in the negative. The operator recommended the caller contact the Medi-Cal office and provided the address and phone number. The operator stated the process should take about 30-60 days. The operator further stated caller could still make an appointment to be seen in their clinic, and provided the address and hours of operation. The caller asked if he/she could walk into their clinic and receive services without making an appointment. The operator stated the only way the caller could be seen was by appointment. The operator explained the intake appointment would take approximately 2 hours with 30 minutes set aside for the clerical portion, which consisted of filling out various forms. The only walk-in services that were available were for those individuals that were experiencing a crisis. The operator asked the caller if he/she felt like harming himself/herself or others. The caller replied in the negative. The operator reiterated their appointment policy to receive services. The caller stated he/she was just calling to obtain information, but would call back and schedule an

appointment when he/she was ready. The caller also asked operator what he/she needed to bring to his/her appointment. The operator stated caller should bring his/her photo I.D., Medi-Cal information and proof of income to his/her appointment.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was also provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

FINDINGS

Test Call Results Summary

Protocol Question	Test Call Findings								Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7		
9a-1	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A
9a-2	IN	IN	IN	IN	N/A	N/A	IN		100%
9a-3	IN	IN	IN	IN	IN	N/A	N/A		100%
9a-4	N/A	N/A	N/A	N/A	IN	IN	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 includes requests made by phone, in person, or in writing. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy & Procedure CLN 17:15 Access Line and Contact Log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, three (3) out of the five (5) test calls logged did not include the required elements.

The table below details the findings:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request

1	4/10/17	8:39 p.m.	OUT	OUT	OUT
2	4/13/17	7:36 a.m.	OUT	OUT	OUT
3	4/10/17	2:40 p.m.	IN	IN	OUT
4	3/16/17	1:56 p.m.	IN	IN	IN
7	4/26/17	8:42 a.m.	IN	IN	IN
Compliance Percentage			**60%**	**60%**	**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 questions B10a, B10b, and B10c are 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) complies with all regulatory requirements.

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SECTION C: AUTHORIZATION

PROTOCOL REQUIREMENTS	
C1.	Regarding the Treatment Authorization Requests (TARs) for hospital services:
C1a.	Are the TARs being approved or denied by licensed mental health or waivered/registered professionals of the beneficiary's MHP in accordance with title 9 regulations?
C1b.	Are all adverse decisions regarding hospital requests for payment authorization that were based on criteria for medical necessity or emergency admission being reviewed and approved in accordance with title 9 regulations by: 1) a physician, or 2) at the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under the psychologist's scope of practice?
C1c.	Does the MHP approve or deny TARs within 14 calendar days of the receipt of the TAR and in accordance with title 9 regulations?
• *CCR, title 9, chapter 11, sections 1810.242, 1820.220(c),(d), 1820.220 (f), 1820.220 (h), and 1820.215.* • *CFR, title 42, section 438.210(d)*	

FINDINGS

The MHP did not furnish evidence it complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services. DHCS reviewed the MHP's authorization policy and procedure: P&P #1600 Inpatient treatment Authorization Requests; TAR/Inpatient Census Log; and the List of licensed/waiver/registered staff on TAR logs. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, three (3) of 68 TARS reviewed were approved past the 14 calendar days of receipt. The TAR sample review findings are detailed below:

PROTOCOL REQUIREMENT	# TARS IN COMPLIANCE	# TARs OOC	COMPLIANCE PERCENTAGE

C1a	TARs approved or denied by licensed mental health or waivered/registered professionals	68	0	100%
C1c	TARs approves or denied within 14 calendar days	65	3	96%

Protocol question C1c are 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 complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services.

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 denies payment authorization of a service that has already been delivered to the beneficiary as a result of a retrospective payment determination. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy & Procedures CLN 16:30 Notices of Action. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP could not provide evidence that a NOA-C was issued for two (2) of the denied/modified TARs. 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 D: BENEFICIARY PROTECTION

PROTOCOL REQUIREMENTS

D6.	Is the MHP notifying those providers cited by the beneficiary (or otherwise involved in the grievance, appeal, or expedited appeal) of the final disposition of the beneficiary's grievance, appeal or expedited appeal?
• *CCR, title 9, chapter 11, section 1850.205(d)(6)*	

FINDING

The MHP did not furnish evidence it is notifying those providers cited by the beneficiary (or otherwise involved in the grievance, appeal, or expedited appeal) of the final disposition of the beneficiary's grievance, appeal or expedited appeal. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: P&P CLN: 03:10 Problem Resolution Process and 25 sample grievances. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, two (2) out of the twenty-five (25) grievances reviewed the providers cited by the beneficiary were not notified of the final disposition.

DHCS inspected a sample of 25 grievances to verify compliance with regulatory requirements.

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 notifies providers cited by a beneficiary (or otherwise involved in the grievance) of the final disposition of the beneficiary's grievance, appeal or expedited appeal.

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SURVEY ONLY FINDINGS

SECTION A: NETWORK ADEQUACY

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: Client Services Listing. The documentation provides sufficient evidence of compliance with federal and State requirements. Specifically, the Client Services Listing identifies those beneficiaries receiving ICC and IHBS services from July 2016 thru April 2017 including the service codes and names of the individuals providing the service. 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: Katie A. Services-Intake and Assessment; Katie A. Services-Screening and Referral; Katie A. Eligibility Assessment Form and Mental Health Referral Form. The documentation provides sufficient evidence of compliance with federal and State requirements. Specifically, the Katie A. Eligibility Assessment Form is utilized to ensure that all children/youth referred and/or screened by the MHP's county partners receive assessments. The Mental Health Referral Form is utilized to refer to a MCP for non-specialty mental health services, by a licensed mental health professional or other professional designated by the MHP. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

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

No evidence was provided to demonstrate 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: develop a policy and procedure and amend provider contracts to require that its providers to consent to criminal background checks as a condition of enrollment.

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(D), 438.610, 455.400-455.470, 455.436(B) • DMH Letter No. 10-05 • MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements	

SURVEY FINDING

No evidence was provided to demonstrate 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

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 #: CLN: 22:45 Verification of Contract Providers, Staff, and Applicants-Exclusion and Status Lists; CLN: 32:00 Individual, Group, and Organizational, Provider Selection and Certification; and a sample of verifications competed of providers in the NPPES NPI Registry. The documentation provides sufficient evidence of compliance with federal and State requirements. Specifically, the MHP expects that all individuals and entities that have access to the county's Electronic Health Record or involved in Medi-Cal billing are verified on NPPES during certification/recertification, they must verify on the NPI Registry that the NPI number(s) and related information are accurate, for both individual and organizational/entity providers.
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: Policy and Procedures CLN 09:15 Prescribing Psychotropic Medication to Children In Out-Of-Home Placements; Contracts with pharmacists; Medication Monitoring Checklist; Medication Monitoring referral; and the Medication Monitoring Log. The documentation provides sufficient evidence of compliance with federal and State requirements. Specifically, the policy and procedure documented monitoring of psychotropic medication use, including monitoring psychotropic medication use for children/youth. The medication review process utilizes a reviewer who is licensed to prescribe or dispense prescription drugs. The MHP contracts with two pharmacists to monitor psychotropic medication. The Scope of Services includes a review of a minimum of 10% of all cases involving prescribed medications annually. The reviews will be scheduled once every two (2) months. Review a minimum of six (6) cases during each scheduled review process. The categories for chart selection typically consist of a minimum of three (3) children/youth cases and three (3) adult/older adult cases and three (3) cases that have required inpatient hospitalization, detention in jail/juvenile hall or other type of critical incident involvement. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

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: Policy and Procedures CLN 09:70 Medication Monitoring; Policy and Procedures CLN 27:00 Quality Improvement Program; Medication Monitoring Log; and QIC Meeting Agendas and Minutes. The documentation provides sufficient evidence of compliance with federal and State requirements. The ongoing monitoring activities are detailed in the Annual QI Work Plan, and through those activities and data analysis, significant trends are identified and policy and system-level changes are implemented as appropriate. The policies and procedures require monitoring the service delivery system and meaningful clinical issues affecting beneficiaries, including safety and effectiveness of medication practices by implementing appropriate

interventions and/or professional development when poor quality is identified. The QIC meetings are scheduled every three (3) months, although the Chairperson or MHP Director may schedule a meeting if issues arise. Part of the committee's responsibility is to review medication monitoring processes to assure appropriateness of care. 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

No evidence was provided to demonstrate 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: Develop practice guidelines which meet the requirements of the MHP contract, disseminate the guidelines to all affective providers and make available to beneficiaries and potential beneficiaries, and assure that areas to which the guidelines apply are consistent with the guidelines.

PROTOCOL REQUIREMENTS	
I11.	**Regarding the 1915(b) Special Terms and Conditions (STC)**
I11b.	**SURVEY ONLY** Does the MHP have a system in place for tracking and measuring timeliness of care, including wait times to assessments and wait time to providers?
• *1915(B) Waiver Special Terms and Conditions*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Electronic Health Record. The documentation lacks specific elements to demonstrate

compliance with federal and State requirements. Specifically, the Electronic Health Record that will be used for tracking and measuring timeliness of care, including wait times to assessments and wait time to providers is under construction.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Develop the Electronic Health Record to track and measure timeliness of care, including wait times to assessment and wait time to providers.