FISCAL YEAR (FY) 2017/2018 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
FRESNO COUNTY MENTAL HEALTH PLAN REVIEW
May 7, 2018
FINDINGS REPORT

This report details the findings from the triennial system review of the **Fresno County** Mental Health Plan (MHP). The report is organized according to the findings from each section of the FY 2017/2018 Annual Review Protocol for Consolidated Specialty Mental Health Services (SMHS) and Other Funded Services (Mental Health and Substance Use Disorder Services Information Notice No. 17-050), 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 7 "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 and, if appropriate, send an amended 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	25	3	0/25		100%
SECTION B: ACCESS	54	0	5/54	B2b4, B5e1, B9a4, B13a1, B13a2	91%
SECTION C: AUTHORIZATION	33	3	2/33	C1b,C6a3	94%
SECTION D: BENEFICIARY PROTECTION	29	0	1/29	D2	97%
SECTION E: FUNDING, REPORTING & CONTRACTING REQUIREMENTS	1	0	0/1		100%
SECTION F: INTERFACE WITH PHYSICAL HEALTH CARE	6	0	0/6		100%
SECTION G: PROVIDER RELATIONS	11	0	0/11		100%
SECTION H: PROGRAM INTEGRITY	26	1	1/26	H5a3	97%
SECTION I: QUALITY IMPROVEMENT	34	0	3/34	I3a, I3c, I6f	92%
SECTION J: MENTAL HEALTH SERVICES ACT	21	0	1/21	J4b3	96%

TOTAL ITEMS REVIEWED	**245**	**7**	**13**	

Overall System Review Compliance

Total Number of Requirements Reviewed	245 (with 5 Attestation items)			
Total Number of SURVEY ONLY Requirements	7 (NOT INCLUDED IN CALCULATIONS)			
Total Number of Requirements Partial or OOC	**13**		**OUT OF 245**	
OVERALL PERCENTAGE OF COMPLIANCE	**IN** (# IN/245)	95%	**OOC/Partial** (# OOC/245)	5%

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.

SECTION B: ACCESS

PROTOCOL REQUIREMENTS	
B2. B2a.	Regarding the provider directory: Does the MHP provide beneficiaries with a current provider directory upon request and when first receiving a SMHS?
B2b.	Does the MHP provider directory contain the following required elements: 1) Names of provider(s), as well as any group affiliation?
	2) Street address (es)?
	3) Telephone number(s)?
	4) Website URL, as appropriate?
	5) Specialty, as appropriate?
	6) Whether the provider will accept new beneficiaries?
	7) The provider's cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled interpreter?
	8) Whether the provider has completed cultural competence training?
	9) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment?

• *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*

FINDINGS

The MHP did not furnish evidence it provides beneficiaries with a current provider directory upon request and when first receiving a SMHS and the MHP's provider directory did not contain Website URL, DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Provider Directory policy, and the Fresno County Mental Health Plan Provider Directory. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the Provider Directory did not include the provider's websites. Protocol question B2b (4) is deemed OOC.

PLAN OF CORRECTION

The MHP provided an updated Provider Directory during the review that included the provider's website. A POC addressing the OOC findings for these requirements is not required.

PROTOCOL REQUIREMENTS	
B5e.	Does the MHP ensure its written materials comply with the following: 1) Use easily understood language and format (i.e., 6th grade reading level)?
	2) Use a font size no small than 12 point?
• *CFR, title 42, section 438.10(d)(i),(ii)* • *CCR, title 9, chapter 11, sections 1810.110(a) and 1810.410(e)(4)*	• *CFR, title 42, section 438.10(d)(2)* • *MHP Contract, Exhibit A, Attachment I*

FINDINGS

The MHP did not furnish evidence it ensures its written materials comply with easily understood language and format (i.e., 6th grade reading level). The MHP did not provide any evidence of compliance. The MHP stated that currently they have no formal way to verify the reading level of their written materials. Protocol question B5e (1) 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 ensure its written materials comply with easily understood language and format (i.e., 6th grade reading level) and use a font size no small than 12 point.

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 March 1, 2018, at 10:22 a.m. The call was answered after six (6) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator started the call with asking, "Is this an emergency". The caller responded that it is not emergency. Then the operator asked the caller to provide his/her name, age and phone number. The caller gave first and last name but declined to give age and phone number. The operator verified the service needs with the caller, then provided phone number, address and type of services available at the urgent care wellness center and crisis services in Fresno. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and the caller was 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 #2 was placed on April 12, 2018, at 7:29 a.m. The call was answered after four (4) rings via a live operator. The operator informed the caller that he/she reached the access line and asked if this was an emergency. The caller replied in the negative. The operator asked the caller if he/she needed an interpreter. The caller replied in the negative. The operator asked the caller for his/her name, telephone number, age, and what insurance the caller had. The caller provided his/her name, age, and insurance information however, declined to provide a telephone number. Upon answering the operator's questions, the caller requested information about how to access services. The operator asked the caller if he/she was in crisis or having any thoughts of hurting him/herself or others. The caller replied in the negative. The operator informed the caller that if not in crisis that the operator would provide information about the walk in clinic for Mental Health Services which include an array of services. The operator provided the caller the clinics hours of operation, address, and telephone number. The caller thanked the operator and ceased the call. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, the caller was provided information about services needed to treat a beneficiary's urgent condition and an interpreter.

The call is deemed In compliance with the regulatory requirements for protocol questions B9a1, B9a2, and B9a3.

Test Call #3 was placed on April 3, 2018, at 7:39 a.m. The call was answered after two (2) rings via a live operator. The operator provided his/her name, offered interpreter services, and questioned whether the call was for an emergency. The caller requested information about filing a grievance in the county. The operator asked the caller to provide his/her name and phone number in case the call was disconnected, but graciously accepted the caller declining to provide that information. The operator provided two methods to file a complaint. First, by providing the phone number for Managed Care; and secondly, by offering to e-mail Managed Care to request they return the call. The first method requires the beneficiary to dial again to gain the information that the 24/7 line should provide, the second method requires a return call from the MHP. Prompts for further information did not encourage more information on the grievance process. The operator offered interpretation services, inquired about the caller's current condition, but did not provide information on how to file a grievance.

The call is deemed in compliance with the regulatory requirements for protocol questions B9a1, and B9a3. The call is deemed out of compliance with regulatory requirements for protocol question B9a4.

Test Call #4 was placed on April 5, 2018 at 12:03 p.m. The call was answered after one (1) ring via a live operator. The operator provided his/her name, asked the caller if it was an emergency. The caller replied in the negative. The operator asked if he/she could get the caller's phone number to call in case the call got disconnected. The caller said he/she would rather not give his/her phone number. The operator asked for the caller's name. The caller provided a name. The operator asked if the caller was having suicidal thoughts of hurting him/herself. The caller replied in the negative. The operator asked how he/she could help. The caller said he/she is feeling depressed, sad, and overwhelmed due to being the sole caretaker for his/her mother. The operator gave the caller the address, phone number, and hours of operation to the 24 hour crisis stabilization center. The caller stated he/she just wanted to talk with a counselor. The operator asked if the caller was linked to mental health services, the caller responded in the negative. The operator asked what type of health insurance the caller had. The caller said Medi-Cal. The operator gave the address, phone number, and hours of operation to the outpatient clinic. The operator explained that the caller could walk in from 9 a.m. to 5 p.m. to be assessed and linked to mental health services. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and the caller was 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 10, 2018, at 3:55 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 and not feeling like his/herself. The operator asked for the caller's name. The operator asked if the caller was in crisis, or wanting to hurt him/herself or others. The caller responded in the negative. The operator asked if the caller was a Fresno County

resident and the caller replied yes. The operator asked if the caller has ever been seen for mental health services or been on psychotropic medication before. The caller replied in the negative. The operator asked if the caller wanted to be seen for counseling and the caller replied yes. The operator provided two options: 1) Urgent Care Wellness Center, no appointment necessary, walk-in hours are Monday through Friday, 8:00 a.m. to 5:00 p.m. This center is part of Fresno County Behavioral Health. Phone number is 559-600-9171 and located at 4441 East Kings Canyon Road, Fresno, CA 93702. Care Team provides assessment and can refer out to providers. 2) For Crisis situations, if harming self/others, can't groom self, etc., can be seen on walk-in basis at 24-hour stabilization center called Exodus Recovery. Address is 4411 East Kings Canyon Road, Fresno, CA 93702, phone number is 559-453-1008. The operator also explained to call 911 for emergency or go to emergency room if needed. No additional information about SMHS was provided to the caller. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and the caller was 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 #6 Test call was placed on April 19, 2018, at 8:04 a.m. The call was answered after one (1) ring via a live operator. The operator answered the phone and introduced him/herself. The operator asked if it was an emergency. The caller replied in the negative. The operator asked for the caller's phone number, and personal info. The caller indicated that he/she was calling regarding his/her son who was having issues at school and at home. The caller indicated he/she was worried about his/her son's behavior and was referred to mental health services by the son's doctor. The operator asked the caller to provide the son's DOB (04/05/2005) and son's name (Darren Gomez). The operator asked if the caller had prior mental health issues or if the caller believed he/she would hurt him/herself or others. The caller indicated that he/she did not believe he/she was a threat to him/herself or others. The operator asked if the son had any drug use, the caller indicated that he/she was not aware of any. The operator indicated that the caller could walk in to the Children's Mental Health center, located at 3133 N. Millbrick, Fresno CA and pick up an application to get the process started. The operator indicated that the caller would need legal guardian documents such as a birth certificate and could go to the center M-F, 7:30 a.m-5 p.m. The operator stated that for the initial application the child does not have to be present. The operator also provided the phone number for the center.

The operator also indicated that if the child was in a crisis the caller could call 911 at any time and let them know they previously spoke with Fresno county SMHS and they could provide crisis services. Or indicated the caller could take his/her son to the crisis center located at 4411 East Kings Canyon Rd, Fresno CA. The crisis center is open 24/7 for services and the operator provided the phone number. The operator also indicated that he/she could call back on the access line for any additional help. The operator asked if the caller had any additional questions or if he/she needed more info regarding the process. The caller confirmed that the/she would go to the center to get an application and start the process. The operator confirmed that this was the first step in getting the child SMHS. The caller thanked the operator and ended the call. The caller was provided information about how to access SMHS, including SMHS required to

assess whether medical necessity criteria are met, and the caller was provided information about services needed to treat a beneficiary's urgent condition

Test call was deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #7 Test call was placed on April 19, 2018, at 12:21 p.m. The call was answered after two (2) rings via a live operator. The caller explained that he/she wanted to know what to do to file a complaint. The operator asked for caller's first and last name and if the caller needed an interpreter. The caller provider his/her name and responded in the negative to needing an interpreter. The operator explained that for a grievance, the caller had the right to change the provider and that someone from managed care can help and provided the phone number. Another option is that the information could be mailed to the caller, the operator then requested the callers address. The operator also stated the caller could come and pick up the information in person and provided the address: 4409 East Inyo Avenue, Mode. A, Fresno, CA 93702. In addition, the caller could go to urgent care center to pick up the information. The operator also added that the appeal processing takes 3 working days. The caller thanked the operator and ended the call**.** The caller was offered interpreter services, and provided information about how to use the beneficiary problem resolution process.

Test call was deemed in compliance with the regulatory requirements for protocol questions B9a1 and B9a4.

FINDINGS

Test Call Results Summary

Protocol Question	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
9a-1	N/A	IN	IN	N/A	N/A	N/A	IN	**100%**
9a-2	IN	IN	N/A	IN	IN	IN	N/A	**100%**
9a-3	IN	IN	IN	IN	IN	IN	N/A	**100%**
9a-4	N/A	N/A	OOC	N/A	N/A	N/A	IN	**50%**

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy and Procedure (P&P) Access/Referrals 24 hour toll Free Beneficiary Access Line, test call quarterly update report form, and the Exodus Access Line Script. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Protocol question 9a-4 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 it provides a statewide, toll-free telephone number 24 hours a day, 7 days per week, with language capability in all languages spoken by beneficiaries of the county that will provide

information to beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

PROTOCOL REQUIREMENTS	
B13a.	Regarding the MHP's plan for annual cultural competence training necessary to ensure the provision of culturally competent services:
	1) Is there a plan for cultural competency training for the administrative and management staff of the MHP?
	2) Is there a plan for cultural competency training for persons providing SMHS employed by or contracting with the MHP?
	3) Is there a process that ensures that interpreters are trained and monitored for language competence (e.g., formal testing)?
B13b.	Does the MHP have evidence of the implementation of training programs to improve the cultural competence skills of staff and contract providers?
• *CCR, title 9, chapter 11, section 1810.410 (a)-(e)* • *DMH Information Notice No. 10-02, Enclosure, Pages 16 & 22 and DMH Information Notice No. 10-17, Enclosure, Pages 13 & 17* • *MHP Contract, Exhibit A, Attachment I*	

FINDINGS

The MHP did not furnish evidence it has a plan for annual cultural competence training necessary to ensure the provision of culturally competent services. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: MHP provided the following training documentation: Empowering Black Families and Communities through Resiliency, Restoration, and Reconnection, KHMER Cross Cultural Education workshop, Islamic Culture Awareness Training, Cultural Competence Summit XX: Supporting Community defined practices, 5th annual Latino conference, 2017 Asian Pacific Islander Mental Health Empowerment Conference, Hmong Spiritual Healing & Mental Health, Fostering Growth in Cultural and Linguistic Competence, LGBTQ 101 Training including sign in sheets for the attendees, and the County Employees Core Training Participation Rate log. HEMCDT (Health Equity and Multicultural Training): This training started in August of 2017 and is targeted for 100% of Fresno County Department of Behavioral Health (DBH) staff as well as a percentage of each contracted program. The MHP has implemented a variety of cultural competency activities since the hiring of their Ethnic Services manager. The MHP hosts 2-day trainings for 45 people twice per month and this is scheduled to go through September of this year to capture all DBH staff and as many of the contracted provider staff as possible. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP did not have a tracking system that identified cultural competency training for administrative and management staff and/or persons providing SMHS employed by or contracting with the MHP that was implemented during the triennial review period. Protocol questions B13a (1) and B13a (2) 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 plan for annual cultural competence training necessary to ensure the provision of culturally competent services. Specifically, the MHP must develop a plan for, and provide evidence of implementation of, cultural competency training for administrative and management staff as well as persons providing SMHS employed by or contracting with the MHP. The MHP must develop a process to ensure interpreters are trained and monitored for language competence.

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SECTION C: COVERAGE AND 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.	Does the MHP approve or deny TARs within 14 calendar days of the receipt of the TAR and in accordance with title 9 regulations?
C1c.	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?
• *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

DHCS inspected a sample of 100 TARs to verify compliance with regulatory requirements. The TAR sample review findings are detailed below:

PROTOCOL REQUIREMENT		# TARS IN COMPLIANCE	# TARs OOC	COMPLIANCE PERCENTAGE
C1c	Adverse decisions based on criteria for medical necessity or emergency admission approved by a physician (or psychologist, per regulations)	99	1	99%

These TARs did not include evidence that adverse decisions based on criteria for medical necessity or emergency admission were reviewed and approved by a physician (or by a psychologist, per regulations). Protocol question C1c 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 complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services.

PROTOCOL REQUIREMENTS	
C6.	Regarding Notices of Adverse Benefit Determination (NOABDs):
C6a.	Does the MHP provide a beneficiary with a NOABD under the following circumstances: 1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit?
	2) The reduction, suspension, or termination of a previously authorized service?
	3) The denial, in whole or in part, of a payment for service?
	4) The failure to provide services in a timely manner?
	5) The failure to act within timeframes provided in 42 C.F.R. §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals?
	6) The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities?

- *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 NOABD to the beneficiary when, failure to provide services in a timely manner. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: MHP provided letters to beneficiary when contractor would no longer be providing specialty mental health services. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, during the review MHP discussed the ongoing issues with a specific provider, Mental Health Systems Incorporated and their inability to provide services in a timely manner. Although the MHP developed POC's with this contractor, they failed to ensure that the beneficiary received the required NOABD regarding timeliness. Protocol question(s) C6a (4) is deemed in partial compliance.

# Elements	# of Elements OOC	COMPLIANCE PERCENTAGE
6	**1**	**84%**

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 NOABD to the beneficiary when there is a failure to provide services in a timely manner.

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SECTION D: BENEFICIARY PROTECTION

PROTOCOL REQUIREMENTS	
D2.	The MHP is required to maintain a grievance, appeal, and expedited appeal log(s) that records the grievances, appeals, and expedited appeals within one working day of the date of receipt of the grievance, appeal, or expedited appeal.
D2a.	The log must include: 1) The name or identifier of the beneficiary.
	2) The date of receipt of the grievance, appeal, and expedited appeal.
	3) A general description of the reason for the appeal or grievance.
	4) The date of each review or, if applicable, review meeting.
	5) The resolution at each level of the appeal or grievance, if applicable.
	6) The date of resolution at each level, if applicable.
• *CCR, title 9, chapter 11, section 1850.205(d)(1)*	• *CCR, title 9, chapter 11, section 1810.375(a)*

FINDINGS

The MHP did not furnish evidence it maintains a grievance, appeal, and expedited appeal log(s) that records the grievances, appeals, and expedited appeals within one working day of the date of receipt. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy and Procedure 1.2.11 Consumer Grievance Resolution Process. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, when a contracted provider receives a grievance it is not stamped and entered into a log the day it is received. The grievance is mailed to the MHP. There is no way to verify how long it could take the MHP to receive the grievance and determine if it is logged timely. Protocol question D2 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 maintains a grievance, appeal, and expedited appeal log(s) that records the grievances, appeals, and expedited appeals within one working day of the date of receipt.

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SECTION H: PROGRAM INTEGRITY

PROTOCOL REQUIREMENTS	
H5.	Regarding monitoring and verification of provider eligibility:
H5a.	Does the MHP ensure the following requirements are met: 1) Is there evidence that the MHP has a process in place to verify new and current (prior to contracting/employing and monthly thereafter) providers, including contractors, are not on the Office of Inspector General List of Excluded Individuals/Entities (LEIE)?
	2) Is there evidence that the MHP has a process in place to verify new and current (prior to contracting/employing and monthly thereafter) providers and contractors are not on the DHCS Medi-Cal List of Suspended or Ineligible Providers?
	3) 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?
	4) Is there evidence that the MHP has a process in place to verify the accuracy of new and current (upon enrollment and re-enrollment) providers and contractors in the National Plan and Provider Enumeration System (NPPES)?
	5) Is there evidence the MHP has a process in place to verify new and current (prior to contracting/employing and monthly thereafter) providers and contractors are not in the Excluded Parties List System/System Award Management (EPLS/SAM) database?
H5b.	When an excluded provider/contractor is identified by the MHP, does the MHP have a mechanism in place to take appropriate corrective action?
• *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*

FINDINGS

The MHP did not furnish evidence that is 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. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy PPG 1.3.1 - Screening for Ineligible Persons and (SSDMF) Plan for Implementation agenda. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP identified that they have not started the screening process. The projected target date is December 11, 2018. Protocol question H5a3 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 will verify new and current (prior to contracting/employing) provides and contractors are not in the Social Security Administration's Death Master File.

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SECTION I: QUALITY IMPROVEMENT

PROTOCOL REQUIREMENTS	
I3.	Regarding monitoring of medication practices:
I3a.	Does the MHP have mechanisms to monitor the safety and effectiveness of medication practices at least annually?
• *MHP Contract, Exhibit A, Attachment I*	

FINDING

The MHP did not furnish evidence it has mechanisms to monitor the safety and effectiveness of medication practices at least annually. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: 10-31-17 Meds monitoring Report, multiple Antipsychotic Prescribing Data Reports, Targeted Medication Review process, and Psychiatric Services Agreement. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP reported that difficulty in due to multiple turn over in the Medical Director position. MHP has identified their new prescriber, Central California Faculty Medical Group Inc. and provided the new contract, which was approved on 5-1-18. The contract will provide stable leadership in the psychiatry department. The MHP has made significant progress in the last year however; there was lack of compliance for the first two years of the triennial review period. Protocol question 13a 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 has mechanisms to monitor the safety and effectiveness of medication practices at least annually.

PROTOCOL REQUIREMENTS	
I3c.	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?
• *MHP Contract, Exhibit A, Attachment I*	

FINDING

The MHP did not furnish evidence that 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. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Targeted Medication Review. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, MHP reported that the new-targeted medication review process was implemented in July 2017. They did not have a process for the entire triennial review period. Protocol question I3c 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 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.

PROTOCOL REQUIREMENTS	
I6.	Regarding the QAPI Work Plan:
I6a.	Does the MHP have a QAPI Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed?
I6b.	Does the QAPI 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 QAPI 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 QAPI work plan include a description of completed and in-process QAPI activities, including: 1) Monitoring efforts for previously identified issues, including tracking issues over time?
	2) Objectives, scope, and planned QAPI activities for each year?
	3) Targeted areas of improvement or change in service delivery or program design?
I6e.	Does the QAPI 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 toll-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 QAPI 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)* • *DMH Information Notice No. 10-17, Enclosures, Pages 18 & 19, and DMH Information Notice No. 10-02, Enclosure, Page 23*	• *MHP Contract, Exhibit A, Attachment I* • *CCR, tit. 9, § 1810.410* • *CFR, title 42, Part 438-Managed Care, sections 438.204, 438.240 and 438.358.*

FINDINGS

The MHP did not furnish evidence it has a QM/QI work plan covering the current contract cycle, with documented annual evaluations and necessary revisions, which meets MHP Contract requirements. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Cultural competency QIC Meeting Agenda 10-11-17, Cultural Competency QIC

Meeting Minutes, Cultural Competency sign in sheet 10-11-17, 2012 Cultural Competency Plan and FY 2017-18 Updated Annual Cultural Competency Plan Summary Reports. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the QAPI work plan stated that the Cultural Diversity Committee is responsible to provide updates on the Cultural Competence Plan implementation. MHP verbally explained that the 2012 goals were addressed and now they are working on the updates, but did not provide additional evidence. MHP also reported that the cultural diversity committee has a new coordinator as of January 2018 and they are focusing on making improvements to the plan and consumer engagement. The MHP has made progress since January 2018; however, it lacked evidence of compliance for majority of the triennial review period (2015-2017). Protocol question I6F 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 documented annual evaluations and necessary revisions, which meets MHP Contract requirements.

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SECTION J: MENTAL HEALTH SERVICES (MHSA)

PROTOCOL REQUIREMENTS	
J4. J4a. J4b. J4b. J4b.	Regarding the County's Capacity to Implement Mental Health Services Act (MHSA) Programs: Does the County conduct an assessment of its capacity to implement the proposed programs/services? Does the assessment include: 1) The strengths and limitations of the County and service providers that impact their ability to meet the needs of racially and ethnically diverse populations? 2) Bilingual proficiency in threshold languages? 3) Percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served?
• *CCR, title 9, chapter 14, section 3610*	

FINDINGS

The County did not furnish evidence it has percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served. DHCS reviewed the following documentation presented by the County as evidence of compliance: Pie Charts of MHP employees and clients served based on ethnicity. The penetration rate of clients served for fiscal years 2014-2017. However, it was determined the documentation lacked sufficient

evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP did not demonstrate it has percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served. Protocol question J4b3 is deemed OOC.

PLAN OF CORRECTION

The County must submit a POC addressing the OOC findings for these requirements. The County is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served.

SURVEY ONLY FINDINGS

SECTION A: NETWORK ADEQUACY AND ARRAY OF SERVICES

PROTOCOL REQUIREMENTS	
A6. A6a.	Regarding therapeutic foster care service model services (referred to hereafter as "TFC"): **SURVEY ONLY** 1) Does the MHP have a mechanism in place for providing medically necessary TFC services, either by contracting with a TFC agency or establishing a county owned and operated TFC agency?
	2) If the MHP does not have a mechanism in place to provide TFC, has the MHP taken steps to ensure that TFC will be available to children/youth who require this service, either through contracting with a TFC agency or establishing a county owned and operated TFC Agency?
• *State Plan Amendment 09-004* • *MHSUDS Information Notice No. 17-009* • *MHSUDS Information Notice No. 17-021*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: TFC Request for Proposal (RFP) Number 18-023. RFP closed on February 23, 2018 and a successful bidder has been identified. The agreement will be going to the board on 6-12-18. Contractor will be ramping up for 2-3 months and then going operational. Currently services are provided by Uplift Inc., (the new contract will phase this out) then Golden State foster family agency will take over as the new provider.

SUGGESTED ACTIONS

No further action required at this time.

PROTOCOL REQUIREMENTS	
A7. A7a.	Regarding Continuum of Care Reform (CCR**):** **SURVEY ONLY** Does the MHP maintain an appropriate network of Short Term Residential Therapeutic Programs (STRTPs) for children/youth who have been determined to meet STRTP placement criteria?
• *Welfare and Institutions Code 4096,5600.3(a)*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Letters from Core Conditions, Inc., and DN Associates regarding the request to review program

statement and request for letter of recommendation. The MHP does not have any formal policies. The current status for Fresno County is that no group homes have yet been approved as an STRTP. With the exception of Promesa Behavioral Health, Fresno County group homes are currently somewhere in the process of submitting their applications to the State for STRTP approval. Promesa Behavioral Health is going through its third round of review at the State level and is expected to be approved in the next couple of months.

As part of their process of submitting their applications to the State, group homes need to receive a letter of support/recommendation from the County. In order to receive that letter of support/recommendation, they must submit their program statements to the County for review and approval and these program statements include information on how they plan to provide or ensure access to mental health services for the children/youth placed in their care.
DBH, DSS, and Probation have been meeting, regularly, to review these program statements and provide feedback to the group homes. To date, 8 program statements have been reviewed, 3 letters of support have been written, and the remaining 5 group homes are updating their program statements, based on the County's feedback. The three letters of support were provided to Promesa Behavioral Health, DN Associates, and Core Conditions. As stated above, Promesa is going through its third round of review at the State. Once the STRTP becomes licensed, they have one year from the date of licensure to receive mental health program approval from DHCS.

Additionally, DBH is working on a Master Agreement for STRTPs to provide specialty mental health services to the children/youth placed in their care, once they are licensed and obtain Medi-Cal certification and organizational provider status. They expect to get this Master Agreement to the Board by April/May but, as shown above, there are currently no approved STRTPs in Fresno County. In the interim, we do have our child welfare specialty mental health providers who receive referrals for children in the child welfare system. A number of those children are in group homes and it is the anticipaton that they will help meet the need of these children/youth

SUGGESTED ACTIONS
No further action required at this time.

SECTION C: COVERAGE AND AUTHORIZATION

PROTOCOL REQUIREMENTS	
C4d.	Regarding presumptive transfer: **SURVEY ONLY:** 1) Does the MHP have a mechanism to ensure timely provision of mental health services to foster children upon presumptive transfer to the MHP from the MHP in the county of original jurisdiction?
	SURVEY ONLY: 2) Has the MHP identified a single point of contact or unit with a dedicated phone number and/or email address for the purpose of presumptive transfer?

	SURVEY ONLY: 3) Has the MHP posted the contact information to its public website to ensure timely communication?
• *Welfare and Institutions Code 4096,5600.3(a)*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Presumptive Transfer Online information, Notice of Transfer of AB 1299 Specialty Mental Health Responsibility form, Presumptive Transfer Checklist and Procedure. MHP identified that the point of contact for all presumptive transfers is Aimie Rojas, LCSW (559) 600-8918. The MHP has an email inbox DBHAB1299@co.fresno.ca.us to receive requests from other counties. They are also able to receive referrals by fax however, most requests are received via email. Once they have received the referral they identify what if any information is lacking. At that point they will reach out to the county social worker or clinic contact to get the additional information. In addition to a call, a subsequent email is sent as follow up. Fresno County developed their own Notice of Transfer Form that is sent to identify the required elements. However, the county will receive and accept other county forms as well as their own. Once the information is reviewed, the youth wellness employee will send the completed information to the admitting reviewer to complete the registration portion. After the registration process is completed, a mental health assessment is scheduled.

SUGGESTED ACTIONS

No further action required at this time.

PROTOCOL REQUIREMENTS	
H2k.	Does the MHP have a provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, waste and abuse?
• *CFR, title 42, sections 438.10, 438.604, 438.606, 438.608 and 438.610* • *MHP Contract, Exhibit A, Attachment I*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Policy and Procedure (P&P) 6.1.2 Disallowance Repayment Procedures, P&P 4.3.5 Outpatient Medi-Cal Disallowance and Unauthorized Services, Service Correction Adjustment Request Form, (SCARF) which provides a step-by-step instruction for correcting/adjusting services that are received from staff in order to prevent denials and minimize revenue losses, a sample of submitted Scarfs, Individual results of Medical Record Reviews, How to Guide - for the billing claim replacement, and billing void claims. As a preventative measure the MHP identified that they submit SCARF's to correct or adjust services that are received from staff in order to prevent denials and minimize revenue losses. SCARF's are submitted if there is an UR adjustment and the Treatment Plan or Core Assessment has expired, or if the medical necessity information does not match the diagnosis. They can back out the billing due to the service not being billable. There could also be a duplicate service and the duplicate request is then deleted when submitting the SCARF. The last type correction would be for a service adjustment and this would require that the service field would have to be adjusted. If there is a disallowance the

Finance Division will process all disallowances identified through the State's Void and Replace process within 60 days of notification from the program staff or County's compliance office.

SUGGESTED ACTIONS

No further action required at this time.