FISCAL YEAR (FY) 2017/2018 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
LAKE COUNTY MENTAL HEALTH PLAN REVIEW
January 22, 2018
FINDINGS REPORT

This report details the findings from the triennial system review of the **Lake 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 2
FINDINGS 3
ATTESTATION 3
SECTION B: ACCESS 3
SECTION C: AUTHORIZATION 9
SECTION E: ..... FUNDING, REPORTING AND CONTRACTING REQUIREMENTS 10
SECTION G: PROVIDER RELATIONS 11

SECTION I: QUALITY IMPROVEMENT 12
SURVEY ONLY FINDINGS 13

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	**2b8; 9a2; 9a3; 9c & 10a**	91%
SECTION C: AUTHORIZATION	33	3	2/33	**1b & 3a1**	94%
SECTION D: BENEFICIARY PROTECTION	29	0	0/29		100%
SECTION E: FUNDING, REPORTING & CONTRACTING REQUIREMENTS	1	0	1/1	**E1**	0%
SECTION F: INTERFACE WITH PHYSICAL HEALTH CARE	6	0	0/6		100%
SECTION G: PROVIDER RELATIONS	11	0	2/11	**3a3 & 3a7**	82%
SECTION H: PROGRAM INTEGRITY	26	1	0/26		100%
SECTION I: QUALITY IMPROVEMENT	34	0	1/34	**10a**	94%

SECTION J: MENTAL HEALTH SERVICES ACT	21	0	0/21		100%
TOTAL ITEMS REVIEWED	**245**	**7**	**11**		

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	**11**		**OUT OF 245**	
OVERALL PERCENTAGE OF COMPLIANCE	**IN** (# IN/245)	96%	**OOC/Partial** (# OOC/245)	4%

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	
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 the provider directory indicates whether the provider has completed cultural competence training. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 115 – Initial Service Provider Selection and Change of Provider Requests (effective 7/1/05; revised 11/10/17) and MHPs Provider List. The provider list did not indicate whether the provider has completed cultural competence training. Protocol question B2b8 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 indicates whether the provider has completed cultural competence training.

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 Monday, December 11, 2017, at 7:28 a.m. The call was immediately answered via a live operator. The operator requested the DHCS test caller's name and the caller requested SMHS in the county. The operator offered to talk with the caller and provided emotional support. The operator advised the caller that he/she had reached the crisis line and could call back during business hours to talk with day staff or have day staff return his/her call. The operator also provided the address and hours of operation for the clinic in Lucerne. The operator provided information regarding Medi-Cal, the screening process, and established that the caller was not suicidal. The operator provided information about how to access SMHS and 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 Monday, November 6, 2017, at 11:43 p.m. The call was immediately answered via a live operator. The DHCS test caller requested information about filing a complaint in the county. The caller requested the complaint remain anonymous. The operator advised the caller that the complaint might remain anonymous unless there are dangerous threats or elder abuse. The operator explained the complaint process and advised the caller that he/she could file a complaint by calling or walking into the clinic to speak with the Quality Improvement team or Pick up a complaint form located in the lobby of the clinic. The operator provided the caller with the address, phone number and hours of operation of the clinic. The caller was provided information about how to use the beneficiary resolution and fair hearing process. The call is deemed in compliance with the regulatory requirements for protocol question B9a4.

Test Call #3 was placed on Wednesday, December 27, 2017, at 7:36 a.m. The call was answered after one (1) ring via a live operator. The DHCS test caller requested information about how to file a complaint with the county. The operator informed the caller that he/she could document the complaint and relay it to the MHP or the caller could pick up a form in the lobby and submit it to the MHP. The operator provided the hours of operations. The caller asked the operator if he/she could file the complaint anonymously. The operator informed the caller that he/she does not think that the caller could file a complaint anonymously when sending in the complaint form. The operator informed the caller again that he/she could take the complaint and relay it to the MHP. The caller declined and informed the operator that he/she would like to think about how he/she would file the complaint. The operator asked the caller how he/she was doing and the caller replied that he/she was doing fine. The caller was provided information about how to use the beneficiary problem resolution and fair hearing processes. The call is deemed in compliance with the regulatory requirements for protocol question B9a4.

Test Call #4 was placed on Wednesday, December 20, 2017, at 8:21a.m. The call was answered after one (1) ring via a live operator. The DHCS test caller requested SMHS in the county. The operator asked the caller to provide son's age and if the caller had Medi-cal. The caller provided son's age and confirmed that he/she had Medi-cal. The operator advised that the call would have to be transferred to a Child Advocate who could provide more information. The caller asked if he/she could bring in son for services. The operator advised the caller that he/she could not bring the child in for services and needed to speak with the Child Advocate first to provide more information. The operator advised that he/she would transfer the call but if the Child Advocate does not answer, the caller should leave a message with contact information for a call back. The call was transferred to the Child Advocates voicemail and the caller disconnected the call. The caller was not provided information about how to access SMHS nor was the caller provided information about services needed to treat a beneficiary's urgent condition. The call is deemed out of compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test call #5 was placed on Wednesday, December 27, 2017, at 7:17 a.m. The call was immediately answered by a live operator. The operator requested the name of the DHCS test caller and if the caller was a client at Lake County. The caller provided name and replied in the negative regarding being a client. The operator then asked for the caller's phone number and the caller declined to provide phone number. The operator asked if the caller was in crisis or feeling suicidal. The caller replied in the negative. The caller requested SMHS in the county. The operator asked if the caller had received SMHS in the past. The caller replied in the negative. The operator explained the assessment process. The operator explained that the caller had reached the afterhours line and offered clinic's hours of operation. The operator provided information regarding walk-in services. The operator provided the address of the two local clinics and the hours of operation for each location. The operator confirmed the closest location for the caller and provided the telephone number. The caller was provided information about how to treat a beneficiary's urgent condition. The caller was also provided information about how to access SMHS. The call is deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #6 was placed on Tuesday, January 2, 2018, at 1:04 p.m. The call was answered after one (1) ring via a live operator. The DHCS test caller requested information about accessing SMHS in the county. The operator asked the caller to provide his/her name, address, DOB, and contact information. The caller provided requested information with the exception of the telephone number. The operator asked the caller to call back and provide a phone number. The operator asked the caller if he/she desired to kill self, hurt self, or others and if he/she had seen there before. The caller replied in the negative. The caller asked if there was a clinic to go to in order to talk to someone. The operator explained that the Intake Team (Crisis Team) process. The operator explained that they have offices in Lucerne and Clear Lake and that the caller reached the Clear Lake office. The operator asked additional questions including insurance information (Medi-Cal). The operator provided hours of operation. The caller was provided information about how to access SMHS 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 #7 was placed on Tuesday, January 9, 2018, at 6:44 a.m. The call was answered after two (2) rings by a live operator. The operator asked for the caller's name and it was provided. The DHCS test caller requested SMHS in the county. The operator asked for the caller's phone number so that the day staff could call her back and provide information on how to access services. The caller declined to give phone number. The operator provided hours of operation to speak with a counselor regarding SMHS. The operator offered counseling services. The operator asked if the caller wanted to hurt himself/herself or if the caller felt suicidal. The caller replied in the negative. The caller told the operator he/she would call the same number during business hours. The call is deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

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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	**Not Applicable**
9a-2	**IN**	N/A	N/A	**OOC**	**IN**	**IN**	**IN**	**80%**
9a-3	**IN**	N/A	N/A	**OOC**	**IN**	**IN**	**IN**	**80%**
9a-4	N/A	**IN**	**IN**	N/A	N/A	N/A	N/A	**100%**

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 102 – Access Line and Contact log (effective 11/8/17) and the MHPs Access Log. Protocol questions B9a2 & B9a3 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 it provides information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, services needed to treat a beneficiary's urgent condition.

PROTOCOL REQUIREMENTS	
B9c.	Does the MHP provide training for staff responsible for the statewide toll-free 24-hour telephone line to ensure linguistic capabilities?
• *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*

FINDING

The MHP did not furnish evidence it provides training for all staff and contractors with responsibilities related to providing a statewide (24/7) toll-free telephone line. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Email dated 12/15/17 regarding coordination of training for the Access Log. Protocol question B9c 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 provides training for all staff and contractors with responsibilities related to providing a statewide (24/7) toll-free telephone line.

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. Specifically, two (2) of the five (5) relevant test calls were not present on the log and as such the beneficiary name, date of request, and initial disposition were not documented. 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	12/11/17	7:28 a.m.	X	X	X
4	12/20/17	8:21 a.m.	**OOC**	**OOC**	**OOC**
5	12/27/17	7:17 a.m.	X	X	X
6	1/2/18	1:04 p.m.	**OOC**	**OOC**	**OOC**
7	1/9/18	6:44 a.m.	X	X	X
Compliance Percentage			**60%**	**60%**	**60%**

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

Protocol question B10a is deemed in partial compliance.

PLAN OF CORRECTION:
The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its written log of initial requests for SMHS (including requests made via telephone, in person or in writing) complies with all regulatory requirements.

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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 **87** TARs to verify compliance with regulatory requirements. The TAR sample review findings are detailed below:

PROTOCOL REQUIREMENT		# TARS IN COMPLIANCE	# TARs OOC	COMPLIANCE PERCENTAGE
C1 a	TARs approved or denied by licensed mental health or waivered/registered professionals	87	0	100%
C1 b	TARs approves or denied within 14 calendar days	86	1	99%

Protocol question C1b 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	
C3.	Regarding payment authorization for Day Treatment Intensive and Day Rehabilitation Services:
C3a.	The MHP requires providers to request advance payment authorization for Day Treatment Authorization and Day Rehabilitation in accordance with MHP Contract:
	1) In advance of service delivery when services will be provided for more than 5 days per week.
	2) At least every 3 months for continuation of Day Treatment Intensive.
	3) At least every 6 months for continuation of Day Rehabilitation.
	4) The MHP requires providers to request authorization for mental health services provided concurrently with day treatment intensive and day rehabilitation, excluding services to treat emergency and urgent conditions.
• *CCR, title 9, chapter 11, sections 1830.215 (e) and 1840.318.* • *DMH Information Notice 02-06, Enclosures, Pages 1-5* • *DMH Letter No. 03-03*	

FINDINGS

The MHP did not furnish evidence it requires providers to request advance payment authorization for Day Treatment Authorization (DTI) and Day Rehabilitation (DR). DHCS reviewed the MHP's authorization policy and procedure: P&P 104 – Day Treatment Intensive (effective 9/18/17). However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the policy did not state that providers are required to request advance payment authorization for DTI and DR in advance of service delivery when services will be provided for more than 5 days per week.

Protocol question C3a1 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 requires providers to request advance payment authorization for DTI and DR in advance of service delivery when services will be provided for more than 5 days per week.

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SECTION E: FUNDING, REPORTING AND CONTRACTING REQUIREMENTS

PROTOCOL REQUIREMENTS	
E1.	Did the MHP comply with the requirements of W&I Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports?
• *Welfare and Institutions Code Sections 14705© and 14712(e)* • *MHSUDS IN No. 17-025*	

FINDINGS

The MHP did not furnish evidence it comply with timely submission of its annual cost reports. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 139 - Cost Report Preparation (effective 12/15/17) and sample of cost reports for fiscal years 2011-12 and 2012-13. The MHP did not submit its most recent annual cost report timely. Protocol question E1 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 comply with timely submission of its annual cost reports.

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SECTION G: PROVIDER RELATIONS

PROTOCOL REQUIREMENTS	
G3. G3a.	Do all contracts or written agreements between the MHP and any subcontractor specify the following: 1) The delegated activities or obligations, and related reporting responsibilities?
	2) The subcontractor agrees to perform the delegated activities and reporting responsibilities in compliance with the MHP's contract obligations?
	3) Remedies in instances where the State or the MHP determine the subcontractor has not performed satisfactorily?
	4) The subcontractor agrees to comply with all applicable Medicaid laws, regulations, and contract provisions, including the terms of the 1915(b) Waiver and any Special Terms and Conditions?
	5) The subcontractor may be subject to audit, evaluation and inspection of any books, records, contracts, computer or electronic systems that pertain to any aspect of the services and activities performed, in accordance with 42 C.F.R. §§ 438.3(h) and 438.230(c)(3)?
	6) The subcontractor will make available, for purposes of an audit, evaluation or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Medi-Cal beneficiaries?

	7) The right to audit will exist through 10 years from the final data of the contract period or from the date of completion of any audit, whichever is later?
	8) If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
• *CFR, title 42, section 438.206(b)(1)* • *CCR, title 9, chapter 11, section 1810.310 (a)(5)(B)*	• *MHP Contract, Exhibit A, Attachment I* • *CMS/DHCS, section 1915(b) waiver*

FINDINGS

The MHP did not furnish evidence that all contracts or written agreements between the MHP and any subcontractor specify: Remedies in instances where the State or the MHP determine the subcontractor has not performed satisfactorily and right to audit will exist through 10 years from the final data of the contract period or from the date of completion of any audit, whichever is later. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Agreement between County of Lake and Remi Vista, Inc for fiscal year 2017-18. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the agreement did not include the following verbiage: Remedies in instances where the State or the MHP determine the subcontractor has not performed satisfactorily and right to audit will exist through 10 years from the final data of the contract period or from the date of completion of any audit, whichever is later. Protocol questions G3a3 and G3a7 are 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 that all contracts or written agreements between the MHP and any subcontractor specify: Remedies in instances where the State or the MHP determine the subcontractor has not performed satisfactorily and right to audit will exist through 10 years from the final data of the contract period or from the date of completion of any audit, whichever is later.

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SECTION I: QUALITY IMPROVEMENT

PROTOCOL REQUIREMENTS	
I10.	Regarding the adoption of practice guidelines:
I10a.	**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 ?**
I10a.	Does the MHP disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries?

I10c.	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*	

FINDING
The MHP did not furnish evidence it has practice guidelines, which meet the requirements of the MHP contract. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: P&P 158 – Practice Guidelines (effective 12/10/17). Protocol question I10a 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 practice guidelines, which meet the requirements of the MHP contract.
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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: Policy 108 – Katie A. Services (effective 10/17/17);

SUGGESTED ACTIONS
No further action required at this time.

PROTOCOL REQUIREMENTS	
A7.	Regarding Continuum of Care Reform (CCR**):**
A7a.	**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: Continuum of care Reform (CCR) implementation guide dated 4/23/17; CCR meeting updates from January 12, 2018 workshop and CCR-STRTP meeting minutes dated 1/10/17.

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
The MHP did not provide evidence that it has a mechanism to ensure timely provision of SMHS to foster children upon presumptive transfer to the MHP from the MHP in the county of original jurisdiction; Identified a single point of contact or unit with a dedicated phone number

and/or email address for the purpose of presumptive transfer; nor posted the contact information to its public website to ensure timely communication.

SUGGESTED ACTIONS

DHCS recommends the MHP implement a mechanism to ensure timely provision of SMHS to foster children upon presumptive transfer to the MHP from the MHP in the county of original jurisdiction; Identified a single point of contact or unit with a dedicated phone number and/or email address for the purpose of presumptive transfer; nor posted the contact information to its public website to ensure timely communication.

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 154 – Reporting Suspected Fraudulent Activity (effective 12/8/17).

SUGGESTED ACTIONS

No further action required at this time.