FISCAL YEAR (FY) 2017/2018 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES SANTA CRUZ COUNTY MENTAL HEALTH PLAN REVIEW FEBRUARY 26 - MARCH 1, 2018 FINDINGS REPORT

This report details the findings from the triennial system review of the **Santa Cruz 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 propose an alternative corrective action plan to DHCS
(5) Description of corrective actions required of the MHP's contracted providers to address findings

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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	1/5	1	80%
SECTION A: NETWORK ADEQUACY AND ARRAY OF SERVICES	25	3	0/25	none	100%
SECTION B: ACCESS	54	0	10/54	2b4, 2b6, 2b8, 9a2, 9a3, 10a, 10b1, 10b2, 10b3, 12c	81%
SECTION C: AUTHORIZATION	33	3	4/33	1b, 2c, 2d, 6a3	88%
SECTION D: BENEFICIARY PROTECTION	29	0	2/29	2a4, 4a1	93%
SECTION E: FUNDING, REPORTING & CONTRACTING REQUIREMENTS	1	0	1/1	1	0%
SECTION F: INTERFACE WITH PHYSICAL HEALTH CARE	6	0	0/6	none	100%
SECTION G: PROVIDER RELATIONS	11	0	1/11	2b	91%

SECTION H: PROGRAM INTEGRITY	26	1	8/26	4a, 4b, 5a1, 5a2, 5a3, 5a4, 5a5, 7	69%
SECTION I: QUALITY IMPROVEMENT	34	0	2/34	2d, 6e4	94%
SECTION J: MENTAL HEALTH SERVICES ACT	21	0	1/21	5b	95%
TOTAL ITEMS REVIEWED	**245**	**7**	**30**		

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	**30**		**OUT OF 245**	
OVERALL PERCENTAGE OF COMPLIANCE	**IN** (# IN/245)	88%	**OOC/Partial** (# OOC/245)	12%

FINDINGS

ATTESTATION

DHCS randomly selected five Attestation items to verify compliance with regulatory and/or contractual requirements.

ATTESTATION REQUIREMENTS	
1.	The MHP must ensure that it makes a good faith effort to give affected beneficiaries written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each enrollee who received his or her primary care form, or was seen on a regular basis by, the terminated provider.
• *CFR, title 42, section 438.10(f)(5)*	

FINDING

The MHP did not furnish evidence it makes a good faith effort to give affected beneficiaries written notice of termination of a contracted provider within 15 days. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: A written statement of what steps the MHP took when a contractor ended their contract with the MHP. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the actions the MHP took did not include a written notification to the provider's beneficiaries. No other policies or documentation was provided. 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 makes a good faith effort to give affected beneficiaries written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each enrollee who received his or her primary care form, or was seen on a regular basis by, the terminated provider.

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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's provider directory did not contain the (1) Website URL, as appropriate, (2) whether the provider will accept new beneficiaries, and (3) whether the provider has completed cultural competence training. Also, the list only contained nine (9) of the MHP's 38 active providers. The MHP's provider directory should contain all active network providers. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Managed Care Provider List, dated 1/2018. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Protocol question(s) B2b4, B2b6, and B2b8 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 the MHP's provider directory contains the Website URL, as appropriate, whether the provider will accept new beneficiaries, and 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 February 10, 2018, at 12:40 pm. The call was answered after 8-10 rings by a live operator. The operated answered "Santa Cruz County Mental Health Services is this call urgent?" The caller responded that he/she didn't know if the call was urgent, and that he/she had Medi-Cal and wanted to start mental health services. The operator told the caller he/she could leave a message since the call was made after hours, and that the operator would need the caller's name and phone number. The caller asked if that was the only option, and the operator responded that the caller could also go to the walk-in clinic at 1400 Emeline building K, Monday through Friday, 8am to 5pm to be evaluated. The operator stated that after an evaluation the county would determine what kind of services the caller was qualified for,and the call ended. The caller was provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, but was not provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol question B9a2, and out of compliance with regulatory requirements for protocol question B9a3.

Test call #2 was placed on February 7, 2018, at 2:14 pm. The call was initially answered after one (1) ring by a live operator. The caller informed the operator that he/she has been feeling down lately, the operator asked the caller for how long. The caller replied, for almost a month.

The caller informed the operator that he/she hasn't been getting much sleep and that a friend told him/her to contact SCBH and get some information on the possible conditions. The operator asked for the caller's name, date of birth, and telephone number in case they were disconnected. The caller complied with the operator's requests. The caller asked for information about services and the operator then asked for the callers Social Security Number or Medi-Cal number. The caller said that he/she wasn't comfortable giving that information out and that he/she just wanted information. The operator then replied that he/she needs the information to refer him/her to a clinician who can then determine what type of services the caller needed. Again, the caller said he/she didn't want to give out that information and the operator reiterated that he/she needs that information to "look the caller up" and progress. The caller asked if there was any information he/she could have and the operator mentioned that he/she is trying to get the caller information, but he/she won't provide the information needed to get further information. The operator asked if they could call him/her back, the caller stated "no, it's fine", and that he/she would call back if anything changes. The caller was not provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, nor was the caller provided information about services needed to treat an urgent condition. The call is deemed OOC with the regulatory requirements for protocol questions B9a2 and B9a3.

Test call #3 was placed on Monday, February 12, 2018, at 8:09 am. The call was answered after one (1) ring via a live operator. The caller stated that he/she needed mental health services because of feeling depressed and overwhelmed, and that he/she needed help. The operator asked what type of insurance the caller had, the caller responded Medi-Cal. The operator asked if the caller would like to speak with someone on the phone then, or to walk into the clinic for an assessment. The caller asked about the walk-in process. The operator stated that the caller would complete paper work, and then be screened by a clinician. The caller stated he/she would like the walk-in process. The operator asked if the caller knew where the Emmeline campus was located, the caller responded no. The operator provided the clinic address as 1400 Emmeline Blvd and 2nd, and the call ended. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, however, the caller was not provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with regulatory requirements for protocol question B9a2, and OOC with regulatory requirements for protocol question B9a3.

Test call #4 was placed on January 31, 2018, at 8:19 am. The call was answered after two (2) rings via a live operator. The operator asked how they could assist the caller. The caller indicated that he/she was calling regarding his/her son who was having issues at school and home. The caller indicated he/she was worried about their son's behavior and was referred to mental health services by the son's doctor. The operator asked the caller to provide son's DOB and son's name. The operator asked if caller had Medi-Cal, caller responded yes. The operator asked if the caller could provide a phone number for a Children Access Worker to call him/her back. The caller refused and stated he/she was unable to answer a phone during work. Caller asked if he/she could bring son in for services. The operator indicated they only have walk-in services for beneficiaries who are suicidal. The operator indicated that the Children Access Worker is offsite so the caller could not reach that person directly as they are

hard to get in touch with, the operator then asked the caller to hold. The call was placed on hold for about 25 seconds, and then answered by a new operator.

The second operator answered and asked how they can help the caller. The caller indicated he/she was just transferred after speaking to a different operator. The operator indicated they were aware of the call and asked caller's sons' age. The operator indicated that they have a mobile emergency response team (MERT) that can respond to those who are suicidal. The operator asked if son was suicidal, the caller responded he was not suicidal. The operator then indicated the caller would have to contact the Access Team and they could conduct a screening to provide further details on how to treat the caller's son. The operator indicated the caller would need to call 800-952-2335 to get in contact with the Access Team. The number the operator provided was the same number the caller originally called. The caller asked if access team was available after hours, the operator stated yes. The caller thanked the new operator and ended the call.

The caller was not provided information on 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. The call is deemed OOC with regulatory requirements for protocol question B9a2, and in compliance for protocol question B9a3.

Test call #5 was placed on February 1, 2018, at 7:36 am. The call was answered after ten (10) rings via a live operator. The operator asked the caller if the call was urgent, the caller replied in the negative. The operator then asked for the caller's first/last name and phone number. The caller provider his/her name and declined to offer the phone number because the caller was using a friend's phone. The operator asked if the caller was calling for substance use disorder, the caller replied in the negative. The operator asked if the caller was a current patient, the caller replied in the negative. The operator asked if the caller was calling for him/herself, the caller replied yes. The operator informed the caller that he/she could walk into the clinic located at 1400 Emeline building K Monday-Friday, from 8:00 am- 5 pm. The operator also added they could take a message and forward the information to the office since the caller had called the after-hours line. The caller was also provided the option to call during business hours. The caller declined the option to leave a message and opted to go to the clinic. 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.

Test call #6 was placed on February 12, 2018, at 9:08 pm. The call was initially answered after five (5) rings via a live operator, "good evening, county mental health services is this urgent?" The caller stated he/she wanted to file a grievance against their therapist and asked what the process was. The operator stated the caller could call the same number during business hours, then stated "oh yes, I have a message I can read to you". The operator then read "I can take a message for you and relay that to the county contact, or you can go to any provider office and pick up a grievance form, or you could contact the county office by phone to file a complaint". The caller was provided information about the beneficiary problem

resolution process. The call is deemed in compliance with the regulatory requirements for protocol questions B9a3 and B9a4.

Test call #7 was placed on February 12, 2018, at 8:53 am. The call was initially answered after two (2) rings via a live operator. The caller explained that he/she wanted to file a complaint after seeing a therapist in Santa Cruz County. The operator transferred the caller to the Quality Improvement Department. The caller explained that he/she wanted to file a complaint about a therapist. The operator told the caller that he/she could take the complaint over the phone. The caller stated feeling uncomfortable about doing that and wanted to know if there was an alternative. The operator stated that the form could be mailed or the caller could come to the clinic to pick up the form. The caller opted to have the form mailed to their home. The operator asked if therapy service was conducted at the 1400 Emeline location and the caller replied yes. The operator instructed the caller to mail the form back or drop it off at the clinic between 8:00 am to 5:00 pm, Monday through Friday, and give the form to the receptionist. The caller was provided information about the beneficiary problem resolution process. The call is deemed in compliance with the regulatory requirements for protocol questions B9a4.

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	OOC	IN	OOC	IN	N/A	N/A	**60%**
9a-3	OOC	OOC	OOC	IN	IN	IN	N/A	**50%**
9a-4	N/A	N/A	N/A	N/A	N/A	IN	IN	**100%**

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 3105 Linguistically Appropriate Services. Protocol questions B9a2 and 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 will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and services needed to treat a beneficiary's urgent condition.

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 of initial requests for SMHS includes requests made by phone, in person, or in writing. DHCS reviewed the MHP's Avatar Access database on site, as the EHR was unable to print out a report for initial requests. DHCS also reviewed emails from the contractor, who receives and processes after hours access calls. The contractor sends email records to the MHP each morning containing the details of calls received. The MHP stated the Access Team reviews the contractor call records and calls the clients back. The Access team then enters the call information into the Avatar medical record. If a caller does not leave a call back number, no medical record is created and the call is not logged. Of the five (5) test calls made requiring logging, none of the calls were logged in Avatar. The DHCS team did review contractor emails and found two of the after hour test calls, however those calls were never logged by the MHP.

In addition, the logs made available by the MHP did not include all required elements for calls. 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	2/10/18	12:40pm	Not found	Not found	Not found
2	2/7/2018	2:14pm	Not found	Not found	Not found
3	2/10/18	8:09am	Not found	Not found	Not found
4	1/31/18	8:19am	Not found	Not found	Not found
5	2/1/18	7:36am	Not found	Not found	Not found
Compliance Percentage			**0%**	**0%**	**0%**

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 B10b1, B10b2, and B10b3 are deemed OOC.

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.

PROTOCOL REQUIREMENTS	
B12.	Regarding the MHP's Cultural Competence Committee (CCC):
B12a.	Does the MHP have a CCC or other group that addresses cultural issues and has participation from cultural groups that is reflective of the community?
B12b.	Does the MHP have evidence of policies, procedures, and practices that demonstrate the CCC activities include the following:

	1) Participates in overall planning and implementation of services at the county?
	2) Provides reports to Quality Assurance/ Quality Improvement Program?
B12c.	Does the CCC complete its Annual Report of CCC activities as required in the CCPR?
• *CCR title 9, section 1810.410*	• *DMH Information Notice 10-02 and 10-17*

FINDINGS

The MHP did not furnish evidence that it completes an annual report of CCC activities. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Annual Reports of CCC activities for FYs 2012 through 2015. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, no Annual Reports were provided for two of the three fiscal years of the triennial review period. Protocol question B12c 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 completes an annual report of CCC activities.

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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

The MHP did not furnish evidence it complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services. DHCS reviewed the MHP's Mental Health Managed Care Outpatient Providers Manual. DHCS inspected a sample of 101 TARs to verify compliance with regulatory requirements. 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	101	0	100%
C1b	TARs approved or denied within 14 calendar days	100	1	99%

Protocol question C1b is deemed in partial compliance.

The TAR sample included 1 TARs which was denied based on criteria for medical necessity or emergency admission.

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)	1	0	100%

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	
C2.	Regarding Standard Authorization Requests for non-hospital SMHS:
C2a.	Does the MHP have written policies and procedures for initial and continuing authorizations of SMHS as a condition of reimbursement?
C2b.	Are payment authorization requests being approved or denied by licensed mental health professionals or waivered/registered professionals of the beneficiary's MHP?
C2c.	For standard authorization decisions, does the MHP make an authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional days?

C2d.	For expedited authorization decisions, does the MHP make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and within 72 hours following receipt of the request for service or, when applicable, within 14 calendar days of an extension?
• *CFR, title 42, section 438.210(b)(3)* • *CFR, title 42, section 438.210(d)(1),(2)*	• *CCR, title 9, chapter 11, sections 1810.253, 1830.220, 1810.365, and 1830.215 (a-g)*

FINDINGS

The MHP did not furnish evidence it complies with regulatory requirements regarding standard authorization requests (SARs) for non-hospital SMHS services. DHCS reviewed the MHP's Mental Health Managed Care Outpatient Providers Manual. DHCS reviewed 20 SARS, two (2) of the 20 SARs reviewed were not approved within 14 days. The SAR sample review findings are detailed below:

	PROTOCOL REQUIREMENT	# SARS IN COMPLIANCE	# SARs OOC	COMPLIANCE PERCENTAGE
C2 b	SARs approved or denied by licensed mental health professionals or waivered/registered professionals	20	0	100%
C2c	MHP makes authorization decisions and provides notice within 14 calendar days	18	2	90%
C2 d	MHP makes expedited authorization decisions and provide notice within 72 hours following receipt of the request for service or, when applicable within 14 calendar days of an extension.	None	None	None

Protocol question C2c 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 SARs for non-hospital SMHS services.

C6. C6a.	Regarding Notices of Adverse Benefit Determination (NOABDs): 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 (NOA-C) to the beneficiary when a denial, in whole or in part, of a payment for service is rendered. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 3223 Notice of Adverse Benefit Determination, and 101 sample TARs. The MHP could not provide a NOABD (NOA-C) for the one sample TAR that was denied based on medical necessity. Protocol question C6a is deemed in partial compliance.

# Elements	# of Elements OOC	COMPLIANCE PERCENTAGE
1	1	100%

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 a denial, in whole or in part, of a payment for service.

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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 3224 Beneficiary Grievance and Appeal Process. However, it was determined documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the log did not contain the date of each review or, if applicable, review meeting. Protocol question D2a4 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.

2a4, 4a1**PROTOCOL REQUIREMENTS**	
D4.	Regarding notification to beneficiaries:
D4a.	1) Does the MHP provide written acknowledgement of each grievance to the beneficiary in writing?
	2) Is the MHP notifying beneficiaries, or their representatives, of the grievance disposition, and is this being documented?
D4b.	1) Does the MHP provide written acknowledgement of each appeal to the beneficiary in writing?
	2) Is the MHP notifying beneficiaries, or their representatives, of the appeal disposition, and is this being documented?
D4c.	1) Does the MHP provide written acknowledgement of each expedited appeal to the beneficiary in writing?
	2) Is the MHP notifying beneficiaries, or their representatives, of the expedited appeal disposition, and is this being documented?
• *CFR, title 42, section 438.406(a)(2)* • *CCR, title 9, chapter 11, section 1850.205(d)(4)*	• *CFR, title 42, section 438.408(d)(1)(2)* • *CCR, title 9, chapter 11, sections 1850.206(b),(c), 1850.207(c),(h), and 1850.208(d),(e)*

FINDINGS
The MHP did not furnish evidence it provides written acknowledgement and notifications of dispositions to beneficiaries for all grievances, appeals, and expedited appeals. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 3224 Beneficiary Grievance and Appeal process, and 10 sample grievance files. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, one (1) of the ten (10) grievance files reviewed did not contain a written acknowledgement letter.

In addition, DHCS inspected a sample of grievances, appeals, and expedited appeals to verify compliance with regulatory requirements.

	# REVIEWED	ACKNOWLEDGEMENT		DISPOSITION		COMPLIANCE PERCENTAGE
		# IN	# OOC	# IN	# OOC	
Grievances	10	9	1	10	0	90%
Appeals	1	1	0	1	0	100%
Expedited Appeals	0	0	0	0	0	N/A

Protocol question 4a1 is deemed in partial compliance.

PLAN OF CORRECTION
The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides written acknowledgement to beneficiaries for all grievances.
****

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 complied with timely submission of its annual cost reports. DHCS reviewed the status of submission of the MHPs 2014-15 and 2015-16 Cost Report. As of the triennial review neither report has been submitted. The MHP did request an extension for the two Cost Reports, the extension date was to 6/30/2017. No additional extension has been requested. 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	
G2.	Regarding the MHP's ongoing monitoring of county-owned and operated and contracted organizational providers:

G2a.	Does the MHP have an ongoing monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified as per title 9 regulations?
G2b.	Is there evidence the MHP's monitoring system is effective?
• *CCR, title 9, chapter 11, section 1810.435 (d)I*	• *MHP Contract, Exhibit A, Attachment I*

FINDINGS
The MHP did not furnish evidence it has an ongoing and effective monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified per title 9 regulations. DHCS reviewed the following documentation as evidence of compliance: DHCS generated Overdue Provider List, with a data pull on February 19, 2018. One (1) of the MHPs 38 providers was overdue for recertification. Protocol question G2b is deemed in partial compliance.

The table below summarizes the report findings:

TOTAL ACTIVE PROVIDERS (per OPS)	NUMBER OF OVERDUE PROVIDERS (at the time of the Review)	COMPLIANCE PERCENTAGE
38	1	97%

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 an ongoing and effective monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified per title 9 regulations.
****

SECTION H: PROGRAM INTEGRITY

PROTOCOL REQUIREMENTS	
H4. H4a.	Regarding disclosures of ownership, control and relationship information: Does the MHP ensure that it collects the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents, as required in CFR, title 42, sections 455.101 and 455.104 and in the MHP Contract, Program Integrity Requirements?
• *CFR, title 42, sections 455.101 and 455.104*	• *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements*

FINDING
The MHP did not furnish evidence it collects the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents as required in regulations and the MHP Contract. DHCS reviewed the

following documentation presented by the MHP as evidence of compliance: Contract with Netfile for electronic filing of Form 700 for county and contracted staff, Letter dated 11/17/2014 to BOS adding positions to county list of required Form 700 reportees, Organizational Provider contract template Exhibit D which requires annual submission of disclosure in March. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements because the MHP could not produce any disclosure samples as evidence of them collecting disclosures from their providers. Protocol question H4a is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it collects the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents as required in regulations and the MHP Contract.

PROTOCOL REQUIREMENTS	
H4b.	Does the MHP require its providers to consent to criminal background checks as a condition of enrollment per 42 CFR 455.434(a)?
H4c.	Does the MHP require providers, or any person with a 5 percent or more direct or indirect ownership interest in the provider to submit a set of fingerprints per 42 CFR 455.434(b)(1)?
• *CFR, title 42, sections 455.101 and 455.104*	• *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements*

FINDING

The MHP did not furnish evidence it requires its providers to consent to criminal background checks as a condition of enrollment. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Contract template Exhibit D. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, this protocol requirement was not included in the contract template, and the MHP provided no other evidence of compliance. Protocol question H4b 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 requires its providers to consent to criminal background checks as a condition of enrollment.

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 (SSDMF)?
	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*

FINDING

The MHP did not furnish evidence it monitors and verifies provider eligibility (prior to contracting and monthly) to ensure providers, including contractors, are not on the OIG LEIE, Medi-Cal List of Suspended or Ineligible Providers, the NPPES, and the EPLS/SAM database. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Exhibit D Contract Template, Policy 3413 Credential Verification, MHP Credentialing Report for New Hires, Draft contract amendment with Med-Advantage (2017-2018). However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, there were gaps between the regulatory requirements and the evidence provided. Unmet requirements: (1) no evidence provided that the MHP screens organizational providers prior to contracting; (2) no evidence was provided demonstrating that the SSDMF is checked; (3) the contract template did not include the requirements that the contractor screen staff prior to hiring, (4) that screening must include a one-time SSDMF check, (5) that NPPES is checked to verify the accuracy of new and current providers and contractors upon enrollment and re-enrollment, (6) no requirements on license verifications, and (7) no frequency is stated for when the exclusion screenings must occur. Protocol questions H5a1, H5a2, H5a3, H5a4, and H5a5 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 it monitors and verifies provider eligibility (prior to contracting and monthly) to ensure providers, including contractors, are not on the OIG LEIE, Medi-Cal List of Suspended or Ineligible Providers, the NPPES, and the EPLS/SAM database.

PROTOCOL REQUIREMENTS	
H7	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*	

FINDING
The MHP did not furnish evidence it verifies that all ordering, rendering, and referring providers have a current National Provider Identifier (NPI) number. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Exhibit D Contract Template, Policy 3413 Credential Verification, MHP Credentialing Report for New Hires, Draft contract amendment with Med-Advantage (2017-2018). However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, although Policy 3413 states Med-Advantage will verify NPI numbers, the Med-Advantage contract scope of work did not include the requirements that the contractor screen staff on NPPES prior to hire or at recertification or at any point, and the MHP did not provide evidence that NPPES is verified prior to contract. Protocol question H7 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 verify that all ordering, rendering, and referring providers have a current National Provider Identifier (NPI) number.

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SECTION I: QUALITY IMPROVEMENT

PROTOCOL REQUIREMENTS	
I2.	Regarding mechanisms to assess beneficiary/ family satisfaction:
I2a.	Does the MHP survey beneficiary/family satisfaction with the Contractor's services at least annually?
I2b.	Does the MHP evaluate beneficiary grievances, appeals, and fair hearings at least annually?
I2c.	Does the MHP evaluate requests to change persons providing services at least annually?
I2d.	Does the MHP inform providers of the results of beneficiary/family satisfaction activities?
• *MHP Contract, Exhibit A, Attachment I*	

FINDINGS

The MHP did not provide any evidence that it informs providers of the results of beneficiary/family satisfaction activities. Protocol question I2d 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 informs providers of the results of beneficiary/family satisfaction activities.

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: FY 2016/17 and 2017/18 Work Plans. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the work plans did not include goals or implemented processes to access after-hours care. Protocol question I6e4 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	
J5b.	Does the County ensure the PSC/Case Manager is responsible for developing an Individual Services and Supports Plan (ISSP) with the client and, when appropriate, the client's family?
J5c.	Does the County ensure the PSC/Case Manager is culturally and linguistically competent or, at a minimum, is educated and trained in linguistic and cultural competence and has knowledge of available resources within the client/family's racial/ethnic community?
J5d.	Does the County ensure that a PSC/Case Manager or other qualified individual known to the client/family is available to respond to the client/family 24 hours a day, 7 days a week to provide after-hours interventions?
• *CCR, title 9, chapter 14, section 3620*	

FINDINGS

The County did not furnish evidence its PSC/Case Managers are responsible for developing an ISSP with the client and, when appropriate, the client's family. DHCS reviewed the following documentation presented by the County as evidence of compliance: Policy# 3322 – Treatment Plan Requirements. The MHP indicated that they use the Treatment Plan as their ISSP. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP does not ensure an ISSP is developed for clients, and when appropriate, the client's family. Protocol question J5b 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 its PSC/Case Managers are developing an ISSP with the client.

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
The MHP explained that they released a Request for Proposal to find a TFC provider. However the estimated number of eligible kids was insufficient to entice any responders. As a result, Santa Cruz MHP is teaming with Monterey and Sen Benito MHPs to produce an RFP with the goal to create a TFC that would serve all three MHPs. The RFP is expected to be completed April or May 2018.

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: Policy 2411-Children's Mental Health Overview of Services, provider contract with Haven of Hope.

The MHP stated that they currently contract with three (3) facilities for STRTP services; Tyler House, Crossroads, and Haven of Hope. They have 12 female beds or 9 male beds. The MHP currently has two (2) kids from Santa Cruz and six (6) kids from out of county (presumptive eligibility) in STRTPs.

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: Policy 2105-Out of County Services for Medi-Cal Beneficiaries; Policy 2433-Presumptive Transfer to Santa Cruz county Children's Behavioral Health; Policy 2435-Presumpive Transfer Out of County. The MHP does have a process in place for foster children via the presumptive transfer. The single point of contact for this activity is the toll free Access line. The MHPs means of informing other MHPs of the process is to post the contact information on its website.

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 4524-Fraud, Waste, Abuse, Federal False Claims; evidence from the Tyler house investigation (audit results, letters, POC). The MHPs accounting section noticed that claiming amounts from the Tyler House provider had increased so they notified QI/QA. QI/QA performed an audit of the provider and identified improper claiming activity. They sent a findings letter to the provider, recouped funds where needed, and required a plan of correction from the provider.

SUGGESTED ACTIONS

No further action required at this time.