

**FISCAL YEAR (FY) 2017/2018 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL
HEALTH SERVICES AND OTHER FUNDED SERVICES
TEHAMA COUNTY MENTAL HEALTH PLAN REVIEW
December 4, 2017
FINDINGS REPORT**

This report details the findings from the triennial system review of the **Tehama 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	PROTOCOL QUESTIONS OUT-OF-COMPLIANCE (OOC) OR PARTIAL COMPLIANCE	COMPLIANCE PERCENTAGE FOR SECTION IN
ATTESTATION	5	0	1/5	Attestation 1	80%
SECTION A: NETWORK ADEQUACY AND ARRAY OF SERVICES	25	0	2/25	A1, A4a	92%
SECTION B: ACCESS	54	0	4/54	B5c, B9a4, B9b, B10s	89%
SECTION C: AUTHORIZATION	33	0	2/33	C1B, C6a4	94%
SECTION D: BENEFICIARY PROTECTION	29	0	1/29	D3a1	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	3/11	G2b, G3a7, G3a8	73%
SECTION H: PROGRAM INTEGRITY	26	1	4/26	H3a, H3b, H4b, H4c	85%
SECTION I: QUALITY IMPROVEMENT	34	0	4/34	I1b, I6a, I6e3, I6e4	88%

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SECTION J: MENTAL HEALTH SERVICES ACT	21	0	9/21	J4a, J4b1, J4b2, J4b3, J6a, J6b1, J6b2, J6b3, J6b4	57%
TOTAL ITEMS REVIEWED	245	7	31		

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	87%	OOO/Partial	13%
	(# IN/245)		(# OOC/245)	

FINDINGS

ATTESTATION

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

ATTESTATION REQUIREMENTS	
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.
<ul style="list-style-type: none"> • <i>CFR, title 42, section 438.10(f)(5)</i> 	

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. 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 A: NETWORK ADEQUACY AND ARRAY OF SERVICES

PROTOCOL REQUIREMENTS	
A1.	Does the MHP have a current Implementation Plan which meets title 9 requirements?
	<ul style="list-style-type: none"> • <i>CCR, title 9, chapter 11, section 1810.310</i>

FINDING

The MHP did not furnish evidence it has a current Implementation Plan which meets title 9 requirements. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Implementation Plan dated August 1997 and Draft PP 03-01-XXXX. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, there is not a current Implementation Plan which meets title 9 requirements. Protocol question A1 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 a current Implementation Plan which meets title 9 requirements.

PROTOCOL REQUIREMENTS	
A4.	Regarding timely access to services:
A4a.	Does the MHP meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency for the need of services?
A4b.	Does the MHP ensure that its providers offer hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service, if the provider serves only Medicaid beneficiaries?
	<ul style="list-style-type: none"> • <i>CFR, title 42, section 438.206(b)(1)</i> • <i>CCR, title 9, chapter 11, section 1810.310</i> • <i>MHP Contract, Exhibit A, Attachment I</i> • <i>CMS/DHCS, section 1915(b) waiver (a)(5)(B)</i>

FINDING

The MHP did not furnish evidence it requires its network providers to meet State standards for timely access to care and services, taking into account the urgency for the need of services. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: PP 03-06-1010, PP 03-07-1140, Assessment wait time spreadsheet, MOU, Provider Contract. However, it was determined the documentation lacked sufficient evidence

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of compliance with regulatory and/or contractual requirements. Specifically, there was no evidence provided that shows time of assessment to service provided. Protocol question A4a is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP require its network providers to meet State standards for timely access to care and services, taking into account the urgency for the need of services.

SECTION B: ACCESS

PROTOCOL REQUIREMENTS	
B5c.	Does the MHP make auxiliary aids and services (e.g., TTY/TDY) available to beneficiaries upon request and at no cost?
<ul style="list-style-type: none"> • <i>CFR, title 42, section 438.10(d)(i),(ii)</i> • <i>CCR, title 9, chapter 11, sections 1810.110(a) and 1810.410(e)(4)</i> 	<ul style="list-style-type: none"> • <i>CFR, title 42, section 438.10(d)(2)</i> • <i>MHP Contract, Exhibit A, Attachment I</i>

FINDINGS

The MHP did not furnish evidence it makes auxiliary aids and services (e.g., TTY/TDY) available to beneficiaries upon request and at no cost. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: PP 8-02-2054, 03-01-1190 (Draft), CRS Procedure. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, there is no MHP TTY/TDY number and it is unclear how beneficiaries are notified how they can access auxiliary aids and services, e.g., TTY/TDY, and informed that it is available upon request at no cost to the beneficiary. Protocol question B5c 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 make auxiliary aids and services (e.g., TTY/TDY) available to beneficiaries upon request and at no cost.

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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?
<ul style="list-style-type: none"> • CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1) • CFR, title 42, section 438.406 (a)(1) 	<ul style="list-style-type: none"> • 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 Wednesday, October 4, 2017, at 7:30 a.m. The call was initially answered without a ring via a live operator for the Crisis Unit. After establishing that there was no crisis, the caller requested information about accessing initial mental health services in the county. The operator provided the address, the hours of operation, phone number and required documentation to receive an assessment at a walk-in clinic that would open within the hour. The operator informed the caller he/she could use the same number for assistance at any time. 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 accessing 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 Tuesday, October 24, 2017, at 7:53 a.m. The call was initially answered after one (1) ring via a live operator. The caller explained the situation to the operator. The operator asked if the caller had received outpatient services recently. The caller replied in the negative and that he/she wanted to find out about services. The operator stated that the caller could come in during business hours to have an assessment and provided the business hours. The caller asked if there was any other information that the caller needed. The operator stated that the caller could call the front desk for an appointment but that everyone had to have an assessment. The caller thanked the operator 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, the caller was not provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in

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compliance with the regulatory requirements for protocol question B9a2 and is deemed OOC for B9a3.

Test Call #3 was placed on Friday, October 27, 2017 at 10:26 a.m. The call was initially answered after one (1) ring via a live operator. The caller explained his/her situation to the operator. The operator asked if there were any particular reasons for these feelings. The caller responded that he/she was not sure. The operator asked for the caller's name. The operator asked if the caller wanted to hurt self or was suicidal and the caller replied in the negative. The operator asked if the caller wanted to start services and the caller wanted to know what that was. The operator explained the process to the caller. The operator provided the address to access services. The operator informed the caller that an appointment could be made to have an assessment done or the caller could go to a walk-in clinic and provided the caller the hours of operation. The operator informed the caller that the Crisis Unit is always open 24/7 if the caller needed to call back and provided the telephone numbers and informed the caller that a nurse and psychiatric aide is on duty. 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 accessing services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #4 was placed on Thursday, November 2, 2017 at 8:19 a.m. The call was initially answered after one (1) ring via a live operator. The Caller requested information on how to access mental health services for his/her son. The operator asked the caller if his/her son had previous mental health issues. The caller replied in the negative. The operator requested information about the caller's son and the caller provided the information. The operator asked if the caller lived in the county. The caller replied "yes". The operator instructed the caller to call the youth empowerment services for youth counseling and explained they will be able to provide the caller with more information. The caller ask the operator for more information on the youth counseling. The operator provided the telephone number, address and hours of operation. The operator also informed the caller that if his/her son is having a crisis, the caller could call back to crisis support. 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 accessing 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 Tuesday, November 14, 2017, at 12:04 p.m. The call was initially answered after one (1) ring via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller what type of insurance the caller has. The caller replied Medi-Cal. The operator provided information about the assessment and evaluation process and provided the address, hours of operation and informed the caller that he/she could walk-in. The operator provided information about how to access SMHS including SMHS required to assess whether medical necessity criteria are met. The operator did not provide 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 is deemed OOC for B9a3.

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Test Call #6 was placed on Thursday, September 29, 2017, at 9:58 p.m. The call was initially answered after two (2) rings via a live operator. The DHCS test caller requested information about filing a complaint in the county. The operator provided location and hours of operation of the MHP as well as names and telephone numbers of administrative staff that could assist in filing a complaint. The caller requested to remain anonymous and inquired about complaint forms in the lobby. The operator advised the caller to call in his/her complaint to aid in anonymity. The operator advised that coming into MHP to complete form might reveal identity. 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 #7 was placed on Tuesday, November 7, 2017 at 7:34 a.m. The call was initially answered after one (1) ring via a live operator. The caller requested information about how to file a complaint with the county. The operator informed the caller that he/she could pick up a complaint form or contact their Compliance Officer. The caller asked the operator how to contact the Compliance Officer. The Operator could not provide the telephone number to the Compliance Office and informed the caller that he/she could contact their Quality Insurance Manager and provided the number. The caller asked the operator how he/she could pick up a complaint form. The operator informed the caller that he/she could pick up a complaint form at any county office or you could request the complaint form to be mailed to you. The caller thanked the operator and ceased the call. 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.

FINDINGS

Test Call Results Summary

Protocol Question	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
9a-1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9a-2	IN	IN	IN	IN	IN	N/A	N/A	100%
9a-3	IN	OOC	IN	IN	OOC	N/A	N/A	60%
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: Crisis Line Test Call Protocol, Test Call Guidelines, and Test Call Report. Protocol question B9a3 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 information about services needed to treat a beneficiary's urgent condition.

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PROTOCOL REQUIREMENTS	
B9b.	Does the MHP provide a statewide (24/7) toll-free telephone number that provides adequate TTY/TDD or Telecommunications Relay Services?
<ul style="list-style-type: none"> • CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1) • CFR, title 42, section 438.406 (a)(1) 	<ul style="list-style-type: none"> • 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 its 24/7 toll-free telephone number provides adequate TTY/TDD or Telecommunications Relay Services. Protocol question B9b 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 its 24/7 toll-free telephone number provides adequate TTY/TDD or Telecommunications Relay Services.

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. 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	10/4/17	7:31 am	OOC	OOC	OOC
2	10/24/17	7:53 am	OOC	OOC	OOC
3	10/27/17	10:26 am	IN	IN	IN
4	11/2/17	8:19 am	OOC	OOC	OOC
5	11/14/17	12:04 pm	OOC	OOC	OOC
Compliance Percentage			20%	20%	20%

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

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Protocol question B10a are deemed in partial compliance.

PLAN OF CORRECTION:

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

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 waived/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: <ul style="list-style-type: none"> 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?
<ul style="list-style-type: none"> • 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 **50** 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 waived/registered professionals	50	0	100%
C1 b	TARs approves or denied within 14 calendar days	49	1	98%

Protocol question C1b are deemed in partial compliance.

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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?
	<ul style="list-style-type: none"> • <i>CFR, title 42, sections 438.10(c), 438.400(b) and 438.404(c)(2)</i> • <i>CCR, title 9, chapter 11, sections 1830.205(a),(b)(1),(2),(3), 1850.210 (a)-(j) and 1850.212</i> • <i>DMH Letter No. 05-03</i> • <i>MHP Contract, Exhibit A, Attachment I</i> • <i>CFR, title 42, section 438.206(b)(3)</i> • <i>CCR, title 9, chapter 11, section 1810.405(e)</i>

FINDINGS

The MHP did not furnish evidence it provides a written NOABD to the beneficiary when the MHP fails to provide services in a timely manner. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Procedure-Notice of Action. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, a NOA-E was not given to the beneficiary. Protocol question C6a4 is deemed in partial compliance.

# Elements	# of Elements OOC	COMPLIANCE PERCENTAGE
6	1	83%

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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 failure to provide services in a timely manner.

SECTION D: BENEFICIARY PROTECTION

PROTOCOL REQUIREMENTS	
D3.	Regarding established timeframes for grievances, appeals, and expedited appeals:
D3a.	1) Does the MHP ensure that grievances are resolved within established timeframes?
	2) Does the MHP ensure that appeals are resolved within established timeframes?
	3) Does the MHP ensure that expedited appeals are resolved within established timeframes?
D3b.	If the MHP extends the timeframe for resolution of a grievance or appeal, does the MHP ensure required notice(s) of an extension are given to beneficiaries in accordance with 42 C.F.R. §438.408(c)?
	<ul style="list-style-type: none"> • <i>CFR, title 42, section 438.408(a),(b)(1)(2)(3)</i> • <i>CCR, title 9, chapter 11, section 1850.207(c)</i> • <i>CCR, title 9, chapter 11, section 1850.206(b)</i> • <i>CCR, title 9, chapter 11, section 1850.208.</i>

FINDINGS

The MHP did not furnish evidence it ensures grievances, appeals, and expedited appeals are resolved within established timeframes. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: PP 03-01-1006 Complaint Resolution Process and Grievance Log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, a grievance was not resolved within the established timeframe.

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

	# REVIEWED	RESOLVED WITHIN TIMEFRAMES		REQUIRED NOTICE OF EXTENSION EVIDENT	COMPLIANCE PERCENTAGE
		# IN COMPLIANCE	# OOC		
GRIEVANCES	18	17	1		94%
APPEALS	None				N/A
EXPEDITED APPEALS	None				N/A

Protocol question(s) D3a1 is deemed in partial compliance.

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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 ensures grievances, appeals, and expedited appeals are resolved within established timeframes.

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?
	<ul style="list-style-type: none"> • CCR, title 9, chapter 11, section 1810.435 • MHP Contract, Exhibit A, Attachment I (d)

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 its Online Provider System (OPS) and generated an Overdue Provider Report which indicated the MHP has providers overdue for certification and/or re-certification. The table below summarizes the report findings:

TOTAL ACTIVE PROVIDERS (per OPS)	NUMBER OF OVERDUE PROVIDERS (at the time of the Review)	COMPLIANCE PERCENTAGE
19	3	84%

Protocol question G2b 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 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.

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PROTOCOL REQUIREMENTS	
G3.	Do all contracts or written agreements between the MHP and any subcontractor specify the following:
G3a.	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.
	<ul style="list-style-type: none"> • <i>CFR, title 42, section 438.206(b)(1)</i> • <i>CCR, title 9, chapter 11, section 1810.310 (a)(5)(B)</i> • <i>MHP Contract, Exhibit A, Attachment I</i> • <i>CMS/DHCS, section 1915(b) waiver</i>

FINDINGS

The MHP did not furnish evidence that all contracts or written agreements between the MHP and any subcontractor specify: 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, and 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. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Contract Boilerplate and Provider Handbook. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the Provider Handbook specifies seven (7) years and does not include that 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. Protocol question(s) G3a7 and G3a8 are deemed OOC.

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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: the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later, and 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.

SECTION H: PROGRAM INTEGRITY

PROTOCOL REQUIREMENTS	
H3.	Regarding verification of services:
H3a	Does the MHP have a method to verify whether services reimbursed by Medicaid were actually furnished to the beneficiaries?
H3b	When unable to verify services were furnished to beneficiaries, does the MHP have a mechanism in place to ensure appropriate actions are taken?
<ul style="list-style-type: none"> • <i>CFR, title 42, sections 455.1(a)(2) and 455.20 (a)</i> • <i>MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements</i> 	<ul style="list-style-type: none"> • <i>Social Security Act, Subpart A, Sections 1902(a)(4), 1903(i)(2) and 1909</i>

FINDINGS

The MHP did not furnish evidence it has a method to verify whether services reimbursed by Medicaid were actually furnished to the beneficiaries and, if unable to verify services, a mechanism to ensure appropriate actions are taken. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Service Verification Stickers policy and Client Service labels. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, while there are service verification stickers and client service labels there is currently no method in place to verify whether services that have been reimbursed by Medicaid were actually furnished to the beneficiaries, and if unable to verify services a mechanism in place to ensure appropriate actions are taken. Pursuant to CFR 42, section 455.20 the agency “must have a method for verifying with beneficiaries whether services billed by providers were received.” Protocol question(s) H3a and H3b 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 has a method to verify whether services billed by providers were received by the beneficiaries, and, if unable to verify services, a mechanism to ensure appropriate actions are taken.

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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)?
<ul style="list-style-type: none"> • <i>CFR, title 42, sections 455.101 and 455.104</i> • <i>MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements</i> 	

FINDING

The MHP did not furnish evidence it require its providers to consent to criminal background checks as a condition of enrollment and 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. Protocol question H4b and H4c are 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 require its providers to consent to criminal background checks as a condition of enrollment and 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.

SECTION I: QUALITY IMPROVEMENT

PROTOCOL REQUIREMENTS	
I1	Regarding the MHP's Quality Assessment and Performance Improvement (QAPI) Program:
I1a	Does the MHP have a written description of the QAPI Program which clearly defines the QAPI Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement?
I1b	Is there evidence the MHP's QAPI Program is evaluated annually and updated as necessary?
<ul style="list-style-type: none"> • <i>CCR, title 9, § 1810.440(a)(6)</i> • <i>MHP Contract, Exhibit A, Attachment I</i> • <i>42 C.F.R. § 438.240(e)</i> 	

FINDINGS

The MHP did not furnish evidence its Quality Management Program is evaluated annually and updated as necessary. Protocol question I1b is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its QM Program is evaluated annually and updated as necessary.

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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?
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?
	<ul style="list-style-type: none"> • <i>CCR, title 9, chapter 11, section 1810.440(a)(5)</i> • <i>DMH Information Notice No. 10-17, Enclosures, Pages 18 & 19, and DMH Information Notice No. 10-02, Enclosure, Page 23</i> • <i>MHP Contract, Exhibit A, Attachment I</i> • <i>CCR, tit. 9, § 1810.410</i> • <i>CFR, title 42, Part 438-Managed Care, sections 438.204, 438.240 and 438.358.</i>

FINDINGS

The MHP did not furnish evidence it has a QA/QI work plan covering the current contract cycle, with documented annual evaluations and necessary revisions, which meets MHP Contract requirements including a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals for Timeliness of services for urgent conditions and access to after-hour care. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: QIC Work Plan and QIC meeting minutes. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, there was no QI Work Plan covering the current contract cycle and the QI Work Plan did not include a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, timeliness of services for urgent conditions, and access to after-hours care. Protocol question I6a is deemed OOC and protocol questions I6e4 and I6e4 are deemed in partial compliance.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has a QM/QI work plan covering the current contract cycle, with documented annual evaluations and necessary revisions, which meets MHP Contract requirements including a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals for Timeliness of services for urgent conditions and access to after-hour care

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SECTION J: MENTAL HEALTH SERVICES (MHSA)

PROTOCOL REQUIREMENTS	
J4.	Regarding the County’s Capacity to Implement Mental Health Services Act (MHSA) Programs:
J4a	Does the County conduct an assessment of its capacity to implement the proposed programs/services?
J4b	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?
<ul style="list-style-type: none"> • <i>CCR, title 9, chapter 14, section 3610</i> 	

FINDINGS

The County did not furnish evidence it has conducted an assessment of its capacity to implement the proposed programs/services which includes strengths and limitations of the County and service providers that impact their ability to meet the needs of racially and ethnically diverse populations, bilingual proficiency in threshold languages, and 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: MHSA three-year plan and Annual Update, Cultural Competency Plan 2010, Demographic and Penetration Rate Reports. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP was unable to provide updated assessment information. Protocol question(s) J4a, J4b1, J4b2, and J4b3 are 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 conduct an assessment of its capacity to implement the proposed programs/services which includes strengths and limitations of the County and service providers that impact their ability to meet the needs of racially and ethnically diverse populations, bilingual proficiency in threshold languages, and 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.

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PROTOCOL REQUIREMENTS	
J6.	Regarding the County's MHSA Issue Resolution Process:
J6a.	Does the County have in place an Issue Resolution Process to resolve issues related to the MHSA community planning process, consistency between approved MHSA plans and program implementation, and the provision of MHSA funded mental health services?
J6b.	Does the County's Issue Resolution Log contain the following information:
	1) Dates the issues were received?
	2) A brief description of the issues?
	3) Final resolution outcomes of those issues?
	4) The date the final issue resolution was reached?
	<ul style="list-style-type: none"> • <i>W&IC 5650</i> • <i>County Performance Contract</i> • <i>W&IC 5651</i>

FINDINGS

Despite not having any disputes to record, the County did not furnish evidence it has an Issue Resolution process or a Resolution Log to track the dates issues were received, a brief description of the issues, final resolution outcomes of the issues, or the date the final issue resolution was reached. Specifically, the County does not maintain an MHSA Issue Resolution Log with all required components. Protocol question(s) J6a, J6b1, J6b2, J6b3, and J6b4 are 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 an Issue Resolution Process to resolve issues related to the MHSA community planning process, consistency between approved MHSA plans and program implementation, and the provision of MHSA funded mental health services. The County must maintain an MHSA Issue Resolution Log with all required components.

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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?
<ul style="list-style-type: none"> • <i>State Plan Amendment 09-004</i> • <i>MHSUDS Information Notice No. 17-009</i> • <i>MHSUDS Information Notice No. 17-021</i> 	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Northern California Training Academy (CCR) and an email to attendees about sharing TFC information at the next meeting.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements or to strengthen current processes in this area to ensure compliance in future reviews: develop a mechanism for providing medically necessary TFC services and 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

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?
<ul style="list-style-type: none"> • <i>Welfare and Institutions Code 4096,5600.3(a)</i> 	

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SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: QIC meeting minutes in which it was indicated that they have received a letter of support from Shasta County for a provider to become a STRTP.

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?
<ul style="list-style-type: none"> • <i>Welfare and Institutions Code 4096,5600.3(a)</i> 	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: PP 03-01-1108 Out-of-County Authorizations for Services, Service Authorization Request (for out-of-county).

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements or to strengthen current processes in this area to ensure compliance in future reviews: Implement 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 and post the MHPs presumptive transfer 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?
<ul style="list-style-type: none"> • <i>CFR, title 42, sections 438.10, 438.604, 438.606, 438.608 and 438.610</i> • <i>MHP Contract, Exhibit A, Attachment I</i> 	

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SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Billing correction form, Service Activity Log (SAL), Disallowance audit tool, Peer Review Audit form, Audit tool for code 106, and emails to staff.

No further action required at this time.