FISCAL YEAR (FY) 2016/2017 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
SHASTA COUNTY MENTAL HEALTH PLAN REVIEW
June 19-22, 2017
FINDINGS REPORT

This report details the findings from the triennial system review of the **Shasta County** Mental Health Plan (MHP). The report is organized according to the findings from each section of the FY 2016/2017 Annual Review Protocol for Consolidated Specialty Mental Health Services (SMHS) and Other Funded Services (Mental Health and Substance Use Disorder Services Information Notice No. 16-045), specifically Sections A-J and the Attestation. This report details the requirements deemed out of compliance (OOC), or in partial compliance, with regulations and/or the terms of the contract between the MHP and DHCS. The corresponding protocol language, as well as the regulatory and/or contractual authority, will be followed by the specific findings and required Plan of Correction (POC).

For informational purposes, this findings report also includes additional information that may be useful for the MHP, including a description of calls testing compliance of the MHP's 24/7 toll-free telephone access line and a section detailing information gathered for the 16 "SURVEY ONLY" questions in the protocol.

The MHP will have an opportunity to review the report for accuracy and appeal any of the findings of non-compliance (for both System Review and Chart Review). The appeal must be submitted to DHCS in writing within 15 business days of receipt of the findings report. DHCS will adjudicate any appeals and/or technical corrections (e.g., calculation errors, etc.) submitted by the MHP and, if appropriate, send an amended report.

A Plan of Correction (POC) is required for all items determined to be out of compliance. The MHP is required to submit a POC to DHCS within 60 days of receipt of the findings report for all system and chart review items deemed out of compliance. The POC should include the following information:

(1) Description of corrective actions, including milestones
(2) Timeline for implementation and/or completion of corrective actions
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS
(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should purpose an alternative corrective action plan to DHCS
(5) Description of corrective actions required of the MHP's contracted providers to address findings

Report Contents

RESULTS SUMMARY: SYSTEM REVIEW

SYSTEM REVIEW SECTION	TOTAL ITEMS REVIEWED	SURVEY ONLY ITEMS	TOTAL FINDINGS PARTIAL or OOC	PROTOCOL QUESTIONS OUT-OF-COMPLIANCE (OOC) OR PARTIAL COMPLIANCE	IN COMPLIANCE PERCENTAGE FOR SECTION
ATTESTATION	5	0	0/5		100%
SECTION A: NETWORK ADEQUACY AND ARRAY OF SERVICES	14	2	0/14		100%
SECTION B: ACCESS	48	0	7/48	5d, 6d3, 8a, 8b, 9a2, 9a3, 13a3	86%
SECTION C: AUTHORIZATION	26	2	7/26	1c, 2a, 2c, 2d, 4b, 6c, 6e	75%
SECTION D: BENEFICIARY PROTECTION	25	0	1/25	3a1	96%
SECTION E: FUNDING, REPORTING & CONTRACTING REQUIREMENTS	**NOT APPLICABLE**				
SECTION F: INTERFACE WITH PHYSICAL HEALTH CARE	6	0	0/6		100%
SECTION G: PROVIDER RELATIONS	6	0	0/6		100%
SECTION H: PROGRAM INTEGRITY	19	4	2/19	3b, 4a	95%
SECTION I: QUALITY IMPROVEMENT	30	8	1/30	6e3	97%
SECTION J: MENTAL HEALTH SERVICES ACT	21	0	2/21	5a, 5b	90%
TOTAL ITEMS REVIEWED	**200**	**16**	**19**		

Overall System Review Compliance

Total Number of Requirements Reviewed	216 (with 5 Attestation items)			
Total Number of SURVEY ONLY Requirements	16 (NOT INCLUDED IN CALCULATIONS)			
Total Number of Requirements Partial or OOC	**19**		**OUT OF 200**	
OVERALL PERCENTAGE OF COMPLIANCE	**IN** (# IN/200)	90%	**OOC/Partial** (# OOC/200)	10%

FINDINGS

ATTESTATION

DHCS randomly selected five (5) Attestation items to verify compliance with regulatory and/or contractual requirements. All requirements were deemed in compliance. A Plan of Correction is not required.

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SECTION B: ACCESS

PROTOCOL REQUIREMENTS	
B5c.	Do these written materials take into consideration persons with limited vision?
B5d.	Do these written materials take into consideration persons with limited reading proficiency (e.g., 6th grade reading level)?
• *CFR, title 42, section 438.10(d)(i),(ii)* • *CCR, title 9, chapter 11, sections 1810.110(a) and 1810.410(e)(4)*	• *CFR, title 42, section 438.10(d)(2)* • *MHP Contract, Exhibit A, Attachment I*

FINDINGS

The MHP did not furnish evidence its written materials take into consideration persons with limited vision and/or persons with limited reading proficiency (e.g., 6th grade reading level). DHCS was not provided any evidence for this protocol requirement. Specifically, the county informed the DHCS they were not performing this task.

Protocol question B5d 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 written materials take into consideration persons with limited vision and/or persons with limited reading proficiency (e.g. 6th grade reading level).

PROTOCOL REQUIREMENTS	
B6d.	Does the MHP have policies, procedures, and practices that comply with the following requirements of title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.
	1) Prohibiting the expectation that family members provide interpreter services?
	2) A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services?
	3) Minor children should not be used as interpreters?
• *CFR, title 42, section 438.10 (c)(4) , 438.6(f)(1), 438.100(d), CFR, title 28, Part 35, 35.160(b)(1), CFR, title 28, Part 36, 36.303(c)* • *CCR, title 9, chapter 11, section 1810.410(a)-(e)* • *DMH Information Notice 10-02 and 10-17*	• *Title VI, Civil Rights Act of 1964 (U.S. Code 42, section 2000d; CFR, title 45, Part 80)* • *MHP Contract, Exhibit A, Attachment I* • *CMS/DHCS, section 1915(b) waiver*

FINDINGS

The MHP did not furnish evidence it has policies, procedures, and practices, in compliance with title VI of the Civil Rights Act of 1964, prohibiting the expectation that family members provide interpreter services, ensuring clients are informed of the availability of free interpreter services before choosing to use a family member or friend as an interpreter, and ensuring

minor children are not used as interpreters. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: HHS Policy and Procedures #21 Use of Tele-and Sign Language Interpreters. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the policy did not include language stating minor children should not be used as interpreters.

Protocol question B6d3 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 policies, procedures, and practices, in compliance with title VI of the Civil Rights Act of 1964, prohibiting the expectation that family members provide interpret services, ensuring clients are informed of the availability of free interpreter services before choosing to use a family member or friend as an interpreter, and ensuring minor children are not used as interpreters.

PROTOCOL REQUIREMENTS	
B8.	Regarding mental health services available to persons who are homeless and hard-to-reach individuals:
B8a.	Is there evidence of assertive outreach to persons who are homeless with mental disabilities?
B8b.	Is there evidence of assertive outreach to hard-to-reach individuals with mental disabilities?
• *W&IC, section 5600.2(d)*	

FINDINGS

The MHP did not furnish evidence of assertive outreach to persons who are homeless with mental disabilities and/or hard-to-reach individuals with mental disabilities. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Staff timesheet logs with code 760 indicating outreach activity was performed. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the timesheets were insufficient and there was no evidence of outreach to the homeless and hard to reach populations.

Protocol questions B8a and B8b 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 conducts assertive outreach to persons who are homeless with mental disabilities and/or hard-to-reach individuals with mental disabilities.

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 May 18, 2017, at 7:24 a.m. The call was initially answered after three (3) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator suggested the caller call back during business hours, but also offered to transfer the caller for immediate assistance. The caller was then placed on hold for three (3) minutes while the call was transferred to another operator. The operator informed the caller to obtain a referral from the doctor and staff could assess services based on the referral. The operator also informed the caller about the walk-in clinic for urgent conditions, 911 services, or they could go to the emergency room. The operator advised the caller that someone from the county would contact the caller later in the week to schedule an assessment. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and provided information about services needed to treat a beneficiary's urgent condition.

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

Test Call #2 was placed on Monday, May 22, 2017 at 8:41 p.m. The call was answered after two (2) rings via a live operator. The operator asked the caller if they were in crisis and required immediate services from a counselor; the caller replied in the negative. The caller requested information about accessing SMHS in the county. The operator advised the caller of the counseling services they had mentioned earlier and advised that they could not assist the caller. The caller again declined immediate counseling services but inquired if appointments were available. The operator advised the caller to call the access line during business hours given to set up an appointment. The caller also asked if they could be seen without an appointment and the operator explained the walk-in appointments were available and provided the address of the clinic. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and 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 #3 was placed on May 23, 2017, at 9:07 a.m. The call was initially answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator placed the caller on hold for one (1) minute and 30 seconds. The operator informed the caller that the walk-in clinic hours are 8:00 a.m. to 3:00 p.m.; Monday through Friday and they could speak to a clinician regarding their symptoms

and discuss a plan of care. The operator provided the address of 2640 Breslauer Way, Redding, CA. Then stated; however, they may be referred to Beacon Health Strategies for counseling services, which accepts Medi-Cal with Partnership. The caller stated having Medi-Cal insurance. The operator did ask for the caller's name, but did not ask for any other identifying information. The operator also explained that if it is after-hours, the caller should go to the ER or call the 888-385-5201 number back. No additional information about SMHS was provided to the caller. The caller was not provided information about 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 a beneficiary's urgent condition.

The call is deemed in compliance with question B9a2 and **out of compliance** with the regulatory requirements for protocol question and B9a3.

Test call #4 was placed on May 26, 2017, at 10:22 a.m. The call was initially answered after one (1) ring via a live-operator. The caller requested information about filing a complaint. The operator informed the caller they could walk-in to pick up the forms and receive assistance, should they need it. The operator also provided information about the types of grievances and the two (2) ways the caller could file a grievance, which is either by phone (530) 245-6750 or in person. The caller was provided with the name Troy who works at the front counter and could assist the caller. The operator asked the caller to provide their name and contact information. The caller stated his name was John and he was borrowing a friend's phone. The caller was provided information on how to use the beneficiary problem resolution process.

The call is deemed in compliance with the regulatory requirements for protocol question B9a4.

Test call #5 was placed on June 4, 2017, at 4:33 p.m. The call was initially answered after five (5) rings via a live operator stating, "You have reached the Shasta County Mental Health Access line, are you in crisis?" The caller responded in the negative and requested information on how to file a complaint. The operator asked the caller's name, the caller responded "Mary". The operator informed the caller there are three (3) ways to file a grievance: the first is, orally by calling (530) 245-6750 or 888-385-5201 during business hours Monday through Friday 8 a.m. – 5 p.m.; the second is by picking up a grievance form at a provider site and the third is by going online at www.co.shasta.ca.us to obtain the form and following the submission instructions. The caller was provided information on how to use the beneficiary problem resolution process, as well as information regarding services needed to treat a beneficiary's urgent condition.

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

Test call #6 was placed on June 2, 2017, at 7:36 a.m. The call was initially answered after three (3) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator instructed the caller to call back after 8:00 a.m. and stated they could provide the caller with the address of the clinic or the phone number, whichever the caller preferred. The caller requested the phone number. The operator provided (530) 225-5200. The caller was not provided information about 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 a beneficiary's urgent condition.

The call is deemed out of compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test call #7 was placed on June 12, 2017, at 7:32 a.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 replied that they could provide a telephone number to call back after 8:00 a.m., or the caller could use the walk-in services between 8:00 a.m. and 5:00 p.m. and provided the address to the clinic. The caller was provided information about 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 B9a2 and out of compliance with the regulatory requirements for protocol question B9a3.

FINDINGS

Test Call Results Summary

Protocol Question	Test Call Findings								Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7		
9a-1	N/A	N/A	N/A	N/A	N/A	N/A	N/A		**100%**
9a-2	IN	IN	IN	N/A	N/A	OUT	IN		**80%**
9a-3	IN	IN	OUT	N/A	IN	OUT	OUT		**50%**
9a-4	N/A	N/A	N/A	IN	IN	N/A	N/A		**100%**

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance: 24/7 Access to Services and Documentation of Request for Specialty Mental Health Services. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the test calls conducted were not provided with information about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met or services to treat a beneficiary's urgent condition.

Protocol questions 9a2 & 9a3 are deemed in partial compliance.

PLAN OF CORRECTION

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition.

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

FINDINGS

The MHP did not furnish evidence it has a process that ensures interpreters are trained and monitored for language competence. The MHP informed DHCS they did not have a Policy and Procedure in place, and were not performing this task. Currently, three (3) MHP clinical staff are providing services in a language other than English. The MHP stated that ten or more years ago, the county policy was to ask staff who wanted to be interpreters several questions in the alternate language. If they answered correctly, staff was approved to provide services in that language. Specifically, the MHP does not currently have a process to ensure interpreters are trained and monitored for language competence.

Protocol question B13a3 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 process in place to ensure that interpreters are trained and monitored for language competence.

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SECTION C: AUTHORIZATION

PROTOCOL REQUIREMENTS	
C1.	Regarding the Treatment Authorization Requests (TARs) for hospital services:
C1a.	Are the TARs being approved or denied by licensed mental health or waivered/registered professionals of the beneficiary's MHP in accordance with title 9 regulations?
C1b.	Are all adverse decisions regarding hospital requests for payment authorization that were based on criteria for medical necessity or emergency admission being reviewed and approved in accordance with title 9 regulations by: 1) a physician, or 2) at the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under the psychologist's scope of practice?

C1c.	Does the MHP approve or deny TARs within 14 calendar days of the receipt of the TAR and in accordance with title 9 regulations?

- *CCR, title 9, chapter 11, sections 1810.242, 1820.220(c),(d), 1820.220 (f), 1820.220 (h), and 1820.215.*
- *CFR, title 42, section 438.210(d)*

FINDINGS

The MHP did not furnish evidence it complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services. DHCS reviewed the MHP's authorization procedure: Managed Care Hospital Review. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP stated they do not have TAR Policies and Procedures but use the procedure "Managed Care Hospital Review". The procedure does not include language that TARs must be approved within 14 calendar days of receipt. In addition, DHCS inspected a sample of 100 TARs to verify compliance with regulatory requirements. The TAR sample review findings are detailed below:

PROTOCOL REQUIREMENT		# TARS IN COMPLIANCE	# TARs OOC	COMPLIANCE PERCENTAGE
C1a	TARs approved or denied by licensed mental health or waivered/registered professionals	100	0	100%
C1c	TARs approves or denied within 14 calendar days	95	5	95%

Protocol question C1c is deemed in partial compliance.

The TAR sample included ten (10) TARs, which were denied based on criteria for medical necessity or emergency admission. All ten (10) were signed by a physician.

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, and approves or denies TARs within 14 calendar days.

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 3 working days 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. The MHP stated they did not have a written policy and procedure for initial and continuing authorizations of SMHS as a condition of reimbursement. DHCS reviewed the MHP's authorization policy and procedure titled "Out of County Review (SAR)". However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the procedure did not contain the SAR authorization requirements, or the expedited authorization process. The SAR process, and the procedure, is only used for kids in Foster, Kin-Gap, and the adoption process. In addition, DHCS inspected a sample of 17 SARs to verify compliance with regulatory requirements. The SAR sample review findings are detailed below:

PROTOCOL REQUIREMENT		# SARS IN COMPLIANCE	# SARs OOC	COMPLIANCE PERCENTAGE
C2b	SARs approved or denied by licensed mental health professionals or waivered/registered professionals	17	0	100%
C2c	MHP makes authorization decisions and provides notice within 14 calendar days	16	1	94%
C2d	MHP makes expedited authorization decisions and provide notice within 3 working days	N/A	N/A	N/A

Protocol question C2c is deemed in partial compliance. Question C2d is deemed OOC due to there not being a process established for expedited appeals.

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, including development of a process for expedited appeals.

PROTOCOL REQUIREMENTS	
C4.	Regarding out-of-plan services to beneficiaries placed out of county:
C4a.	Does the MHP provide out-of-plan services to beneficiaries placed out of county?
C4b.	Does the MHP ensure that it complies with the timelines for processing or submitting authorization requests for children in a foster care, AAP, or KinGAP aid code living outside his or her county of origin?
C4c.	Does the MHP ensure access for foster care children outside its county of adjudication and ensure it complies with the use of standardized contract, authorization procedure, documentation standards and forms issued by DHCS, unless exempted?
• *MHP Contract, Exhibit A, Attachment 1*	

FINDINGS

The MHP did not furnish evidence that it complies with the timelines for processing or submitting authorization requests for children in foster care, AAP, or KinGAP aid code living outside his/her county of origin. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: "Out of County Review (SAR)" procedure, and the SAR

tracking log FY 2014-15 to current. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, even though the SAR procedure stated that SARs must be processed within 3 days, the timeliness data provided varied from 0 to 26 days and the 3-day requirement was not always met. As such, the MHP did not provide sufficient evidence that it complies with the timelines for processing or submitting authorization requests for children in a foster care, AAP, or KinGAP aid code living outside his or her county of origin.

Protocol question C4b 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 complies with the timelines for processing or submitting authorization requests for children in a foster care, AAP, or KinGAP aid code living outside his/her county of origin.

PROTOCOL REQUIREMENTS	
C6c.	NOA-C: Is the MHP providing a written NOA-C to the beneficiary when the MHP denies payment authorization of a service that has already been delivered to the beneficiary as a result of a retrospective payment determination?
• *CFR, title 42, sections 438.10(c), 438.400(b) and 438.404(c)(2)* • *CCR, title 9, chapter 11, sections 1830.205(a),(b)(1),(2),(3), 1850.210 (a)-(j) and 1850.212* • *DMH Letter No. 05-03* • *MHP Contract, Exhibit A, Attachment I* • *CFR, title 42, section 438.206(b)(3)* • *CCR, title 9, chapter 11, section 1810.405(e)*	

FINDING

The MHP did not furnish evidence it provides a written NOA-C to the beneficiary when the MHP denies payment authorization of a service that has already been delivered to the beneficiary as a result of a retrospective payment determination. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: TAR Policy, NOA log, and ten (10) sample denied TARs. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, Ten (10) of the 100 sample TARs reviewed were denied based on medical necessity, and the MHP could not provide evidence that a NOA-C was issued for three (3) of the ten (10) denied TARs.

Protocol question C6c is deemed in partial compliance.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a written NOA-C to the beneficiary when the MHP denies payment authorization of a service that has already been delivered to the beneficiary as a result of a retrospective payment determination.

PROTOCOL REQUIREMENTS	
C6e.	NOA-E: Is the MHP providing a written NOA-E to the beneficiary when the MHP fails to provide a service in a timely manner, as determined by the Contractor (MHP)?

• *CFR, title 42, sections 438.10(c), 438.400(b) and 438.404(c)(2)* • *CCR, title 9, chapter 11, sections 1830.205(a),(b)(1),(2),(3), 1850.210 (a)-(j) and 1850.212* • *DMH Letter No. 05-03*	• *MHP Contract, Exhibit A, Attachment I* • *CFR, title 42, section 438.206(b)(3)* • *CCR, title 9, chapter 11, section 1810.405(e)*

FINDING

The MHP did not furnish evidence it provides a written NOA-E to the beneficiary when the MHP fails to provide a service in a timely manner. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: NOA log, and Timeliness standard data. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the timeliness standard quarterly data showed 5-15% of clients did not receive services within the MHPs 20-day standard. However, only two (2) NOA-Es were issued in FY 2015-16 and FY 2016-17.

Protocol question C6e is deemed in partial compliance.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a written NOA-E to the beneficiary when the MHP fails to provide a service in a timely manner.

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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.	Does the MHP ensure required notice(s) of an extension are given to beneficiaries?
• *CFR, title 42, section 438.408(a),(b)(1)(2)(3)* • *CCR, title 9, chapter 11, section 1850.206(b)*	• *CCR, title 9, chapter 11, section 1850.207(c)* • *CCR, title 9, chapter 11, section 1850.208.*

FINDINGS

The MHP did not furnish evidence it ensures grievances are resolved within established timeframes and/or required notice(s) of an extension are given to beneficiaries. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Beneficiary Problem Resolution Policy and Procedure 2013-04, Grievance Log, and Sample Grievances. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, two (2) of the seven (7) sample grievances where resolved outside of the 60-day timeframe.

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

		RESOLVED WITHIN TIMEFRAMES			
	# REVIEWED	# IN COMPLIANCE	# OOC	REQUIRED NOTICE OF	COMPLIANCE PERCENTAGE

				EXTENSION EVIDENT	
GRIEVANCES	7	5	2	Yes	72%
APPEALS	1	1	0	N/A	100%
EXPEDITED APPEALS	0	N/A	N/A	N/A	N/A

Protocol question D3a1 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 ensures grievances are resolved within established timeframes.

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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?
• *CFR, title 42, sections 455.1(a)(2) and 455.20 (a)* • *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements* • *Social Security Act, Subpart A, Sections 1902(a)(4), 1903(i)(2) and 1909*	

FINDINGS

DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Letter templet for verification of services received, a tracking log for number of letters sent and replies received. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP could not provide any evidence they perform sufficient follow-up when the beneficiary indicates they did not receive the listed services or that it has a mechanism to ensure appropriate actions are taken when services cannot be verified. In addition, the tracking log provided as evidence does not contain sufficient detail or evidence to show the MHP performs follow-up. Subsequently, MHP does not have a Policy and Procedures in place but rather indicated if a beneficiary were to call and billing was in error the MHP would reverse the charges.

Protocol question H3b 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 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.

PROTOCOL REQUIREMENTS	
H4.	Regarding disclosures of ownership, control and relationship information:
H4a.	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: Shasta County Health and Human Services Agency Mental Health Plan, Contractor Code of Conduct, Resolution of the Board of Supervisors, Shasta County Conflict of Interest Code, Compliance Training Handouts, and Code of Conduct Certification. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements.

Specifically, SCMHP did not provide documentation that they are requesting and collecting disclosure of ownership and relationship information from its providers that indicate that the provider either does *or does not* have a direct or indirect ownership interest in the provider, or an ownership on control interest, including managing employees, e.g., a general manager, business manager, administrator, director, or other individual, who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. These disclosures *whether there is ownership or control interest or not* must be available upon request by the state during the review process. Just as Form 700 allows the relevant MHP staff to report whether they do *or do not* have any direct or indirect ownership or control interest, there has to be a mechanism for the providers to do the same, reporting both in the positive and the negative regarding ownership interest. Note that the rules do not apply to ownership exclusively.

- CFR title 42, section 455.101 defines ownership or control interest and explains who is responsible to report disclosures of ownership, control, and relationship information which includes managing employees, e.g., a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

- CFR title 42, section 455.104 explains who must provide disclosures, what must be included, and when disclosures must be provided.

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.

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SECTION I: QUALITY IMPROVEMENT

PROTOCOL REQUIREMENTS	
I6.	Regarding the QM Work Plan:
I6a.	Does the MHP have a QM Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed?
I6b.	Does the QM 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 QM 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 QM work plan include a description of completed and in-process QM activities, including:
	1) Monitoring efforts for previously identified issues, including tracking issues over time?
	2) Objectives, scope, and planned QM activities for each year?
	3) Targeted areas of improvement or change in service delivery or program design?
I6e.	Does the QM 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 QM 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 mechanism implemented to assess the accessibility of services, including goals for timeliness of services for an urgent condition. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: QI Work plan for FY 2016-17. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP could not provide evidence that they have a mechanism to measure timeliness of services for urgent conditions. The MHP stated that they were capturing data from crisis at the Emergency Room only, and not measuring, or capturing other urgent services.

Protocol question I6e3 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 mechanisms to assess timeliness of services for urgent conditions.

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SECTION J: MENTAL HEALTH SERVICES (MHSA)

PROTOCOL REQUIREMENTS	
J5.	Regarding Full Service Partnerships (FSP):
J5a.	Does the County designate a Personal Service Coordinator (PSC)/Case Manager for each client, and when appropriate the client's family, to be the single point of responsibility for that client/family?
• *CCR, title 9, chapter 14, section 3620*	

FINDINGS

The County did not furnish evidence it has designated a PSC/Case Manager for each client, and when appropriate the client's family, to be the single point of responsibility for that client/family. DHCS reviewed the following documentation presented by the County as evidence of compliance: MHP FSP Agency Referral Spreadsheet, and After Hours Emergency Response. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the county had no policy for the FSP, stating that a PSC would be designated for each client, and when appropriate, the client's family, to be the single point of responsibility for that client/family.

Protocol question J5a is deemed OOC.

PLAN OF CORRECTION

The County must submit a POC addressing the OOC findings for this requirement. The County is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has designated a PSC/Case Manager for each client, and when appropriate the client's family, to be the single point of responsibility for that client/family.

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: Client's Treatment Plan. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP had no policy stating that the PSC/Case Manager is responsible to develop an ISSP with the client 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 responsible for developing an ISSP with the client and, when appropriate, the client's family.

SURVEY ONLY FINDINGS

SECTION A: NETWORK ADEQUACY

PROTOCOL REQUIREMENTS	
A4b.	**SURVEY ONLY:** Does the MHP maintain and monitor an appropriate network of providers to meet the anticipated need of children/youth eligible for ICC and IHBS services?
• *Katie A Settlement Agreement* • *Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care for Katie A Subclass Members*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Utilization data of three (3) primary Katie A service providers; Shasta County Health and Human Services FY 2015-16 Mental Health Plan Quality Management Work Plan data count of visits by client's residential area, quarter and service type, including wait time for services and number of services received for ICC and IHBS clients; Shasta County Mental Health Organizational Provider Service Comparison Report, which monitor services and location of services to measure compliance with contract; Shasta County Mental Health Pathways to Mental Health, which monitor Pathways to Mental Health services and location to measure program activity and a Personal Services Agreement (boilerplate). The MHP stated that the Pathways program establishes eligibility, and works closely with Social Services, as do organizational providers. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

PROTOCOL REQUIREMENTS	
A4d.	**SURVEY ONLY:** Does the MHP have a mechanism to ensure all children/youth referred and/or screened by the MHP's county partners (i.e., child welfare) receive an assessment, and/or referral to a MCP for non-specialty mental health services, by a licensed mental health professional or other professional designated by the MHP?
• *Katie A Settlement Agreement* • *Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care for Katie A Subclass Members*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: A patient data collection form and a Katie A survey only form; Utilization data of three (3) Katie A services providers for FY 2016-17; FY 2015-16 QM Work plan data on wait times for services and number of services received for ICC and IHBS clients, contract boilerplate page 23, and client logs. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

SECTION C: AUTHORIZATION

PROTOCOL REQUIREMENTS		
C4d.	**SURVEY ONLY** 1) Does the MHP ensure timely transfer within 48 hours of the authorization and provision of SMHS for a child who will be placed "out of county"?	
	2) Does the MHP have a mechanism to track the transfer of the authorization and provision of services to another MHP?	
• *CCR, title 9, chapter 11, section 1830.220(b)(3) and (b)(4)(A); sections 1810.220.5, 1830.220 (b)(3), and b(4)(A),* • *WIC sections, 11376, 16125, 14716; 14717, 14684, 14718 and 16125*		• *DMH Information Notice No. 09-06,* • *DMH Information Notice No. 97-06* • *DMH Information Notice No. 08-24*

SURVEY FINDING

The MHP provided no evidence for this survey item. The MHP stated that they were not notified of the 48-hour requirement and have no mechanism to meet the requirement at this time. The MHP could not demonstrate compliance with federal and State requirements. Specifically, they are not ensuring timeline transfer within 48 hours or transferring authorization.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Develop a process to ensure timely transfer within 48 hours of the authorization and provision of SMHS for a child who will be placed "out of county", and; also, to develop a mechanism to track the transfer of the authorization and provision of services to another MHP.

PROTOCOL REQUIREMENTS		
C4e.	**SURVEY ONLY** 1) Does the MHP ensure an assessment has been conducted and authorization of services occurs within 4 business days of receipt of a referral for SMHS for a child by another MHP?	
	2) Does the MHP have a mechanism to track referrals for assessments and authorizations of services for children placed in its county?	
• *CCR, title 9, chapter 11, section 1830.220(b)(3) and (b)(4)(A); sections 1810.220.5, 1830.220 (b)(3), and b(4)(A),* • *WIC sections, 11376, 16125, 14716; 14717, 14684, 14718 and 16125*		• *DMH Information Notice No. 09-06,* • *DMH Information Notice No. 97-06* • *DMH Information Notice No. 08-24*

SURVEY FINDING

The MHP maintains a tracking log of children coming into Shasta County for services and Shasta county children receiving services in other counties. The tracking log identifies the

child, county of origin, date SAR sent and received, and total SAR processing days. The authorization processing timeline for SARs coming into Shasta County are four (4) days or less about 95% of the time. The MHP is not currently tracking the assessment date or assessment timeline. DHCS reviewed the following documentation: SAR client logs. The MHPs current practices lack specific elements to demonstrate compliance with federal and State requirements. Specifically, the MHP is not tracking or ensuring assessments are conducted within four (4) business days of a receipt of a referral for SMHS for a child by another MHP.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: The MHP develop a mechanism to track assessment dates and ensure they occur within four (4) business days of a receipt of a referral for SMHS for a child by another MHP.

SECTION H: PROGRAM INTEGRITY

PROTOCOL REQUIREMENTS	
H4b.	**SURVEY ONLY:** Does the MHP require its providers to consent to criminal background checks as a condition of enrollment per 42 CFR 455.434(a)?
• *CFR, title 42, sections 455.101,455.104, and 455.416*	• *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements*

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Department of Support Services Personnel Unit Job Opportunities Bulletin. The MHP did not provide evidence that this requirement is in place for its contract providers. . The MHP should develop a P&P and amend the current provider contracts to include language requiring a provider to consent to criminal background checks as a condition of enrollment.

SUGGESTED ACTIONS

PROTOCOL REQUIREMENTS	
H4c.	**SURVEY ONLY:** 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 455.101,455.104, and 455.416*	• *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements*

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Department of Support Services Personnel Unit Job Opportunities Bulletin. The MHP did not provide evidence that this requirement is in place for its contract providers.

SUGGESTED ACTIONS

The MHP should develop a P&P and amend the current provider contracts to include language requiring any person with five (5) percent or more direct or indirect ownership interest in a provider to submit a set of fingerprints.

PROTOCOL REQUIREMENTS	
H5a3.	**SURVEY ONLY:** Is there evidence that the MHP has a process in place to verify new and current (prior to contracting/employing) providers and contractors are not in the Social Security Administration's Death Master File?
• CFR, title 42, sections 438.214(D), 438.610, 455.400-455.470, 455.436(B) • DMH Letter No. 10-05 • MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements	

SURVEY FINDING

The MHP provided no evidence for this survey question. The MHP stated they were hoping to add the Social Security Administration's Death Master File in their current contract through an amendment.

SUGGESTED ACTIONS

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: Implement a verification check to verify new and current providers/contractors are not on the Social Security Administration's Death Master File placed in the current FY 17/18 contract.

PROTOCOL REQUIREMENTS	
H7.	**SURVEY ONLY:** Does the MHP verify that all ordering, rendering, and referring providers have a current National Provider Identifier (NPI) number?
CFR, title 42, sections 455.410, 455.412 and 455.440	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Provider Certification and Recertification. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

SECTION I: QUALITY IMPROVEMENT

PROTOCOL REQUIREMENTS	
I3b.	**SURVEY ONLY:** Does the MHP have a policy and procedure in place regarding monitoring of psychotropic medication use, including monitoring psychotropic medication use for children/youth?
CFR, title 42, sections 455.410, 455.412 and 455.440	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Medication Monitoring – Adult and Children's Draft and Medication Chart Review. The

documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

PROTOCOL REQUIREMENTS	
I3c.	**SURVEY ONLY:** If a quality of care concern or an outlier is identified related to psychotropic medication use is there evidence that the MHP took appropriate action to address the concern?
• *CFR, title 42, sections 455.410, 455.412 and 455.440*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: HHSA Children's Mental Health Med Team Meeting Agenda, the meeting agenda addressed the following items - Process for reviewing labs, Field visits, Frequency of Clients seeing a Prescriber, and Medication Audits. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

PROTOCOL REQUIREMENTS	
I10. I10a.	Regarding the adoption of practice guidelines: **SURVEY ONLY** Does the MHP have practice guidelines, which meet the requirements of the MHP contract, in compliance with 42 CFR 438.236 and CCR title 9, section 1810.326 ?
I10b.	**SURVEY ONLY** Does the MHP disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries?
I10c.	**SURVEY ONLY** Does the MHP take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other areas to which the guidelines apply are consistent with the guidelines adopted?
• *MHP Contract, Exhibit A, Attachment I* • *42 CFR 438.236*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Progress Notes Training Goals, Assessment Youth Training Goals, Treatment Plan Youth Training Goals, Managed Care & Compliance Tip Sheet, Timeline Requirements for Clinical Documentation, Treatment Plan Policy and Procedures, and Comprehensive Mental Health Assessment and Medication Evaluation Policy and Procedure. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.

PROTOCOL REQUIREMENTS	
I11.	**Regarding the 1915(b) Special Terms and Conditions (STC)**
I11a1	**SURVEY ONLY** Has the MHP submitted data required for the performance dashboard per the STC requirements of the 1915(b) SMHS waiver?
I11a3.	**SURVEY ONLY** Does the MHP's performance data include the performance data of its contracted providers?
I11b.	**SURVEY ONLY** Does the MHP have a system in place for tracking and measuring timeliness of care, including wait times to assessments and wait time to providers?
• *1915(B) Waiver Special Terms and Conditions*	

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Shasta County Health and Human Services Agency - Managed Care Quarterly Dashboard. The documentation provides sufficient evidence of compliance with federal and State requirements.

SUGGESTED ACTIONS

No further action required at this time.