FISCAL YEAR (FY) 2015/2016 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES

PLACER COUNTY / SIERRA COUNTY MENTAL HEALTH PLAN REVIEW
November 2, 2015-November 5, 2015

Excerpt with Response

PLAN OF CORRECTION

SYSTEM REVIEW FINDINGS

SECTION A: ACCESS

Access -Question 9 a		**PROTOCOL REQUIREMENTS**
Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:		
9a	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 PROTOCOL REQUIREMENTS 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, section 1810.405 (d) *CCR, title 9, chapter 11, section 1810 (e) (1)* *CFR, tile 42, section 438.406 (a) (1)*		*DMH Information Notice No. 10-02, Enclosure page 21,* *DMH Information Notice No. 10-17, Enclosure, pg. 16* *MHP Contract, Exhibit A, Attachment I*

DHCS FINDINGS FOR 9a

Test Call Results Summary									
Protocol question	#1	#2	#3	#4	#5	#6	#7	#8	Compliance Percentage
9a-1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Not Applicable
9a-2	N/A	N/A	OCC	OCC	OCC	IN	OCC	OCC	16.67%
9a-3	N/A	N/A	OCC	OCC	OCC	IN	IN	OCC	33.3%
9a-4	OCC	IN	N/A	N/A	N/A	N/A	N/A	N/A	50%

DHCS REQUEST EDPLAN OF CORRECTION FOR QUESTION 9a.

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a statewide, toll-free telephone number 24 hours a day, 7 days per week, with language capabilities in all languages spoken by beneficiaries of the county that will provide information to beneficiaries about how to access SMHS. The information must include SMHS required to assess whether medical necessity criteria are met, services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

Access-Question 10	PROTOCOL REQUIREMENTS
10	Regarding the written log of initial requests for SMHS:
10a.	Does the MHP maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing?
10b.	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)	

DHCS FINDINGS FOR QUESTION 10

The MHP did present evidence its written log(s) of initial requests for SMHS includes requests made by phone, in person, or in writing. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 1001: SOC and the MHP's call log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, DHCS attempted to locate its own test calls on the MHP's log; however, two of the four calls required to be logged were not. The table below details the log results.

Protocol question	Test Calls Logged by Name (10b-1), Date (10b-2) and initial disposition (10b-3)						Percentage
	#3	#4	#5	#6	#7	#8	
10b-1	IN	OCC	IN	IN	OCC	IN	67%
10b-2	IN	OCC	IN	IN	OCC	IN	67%
10b-3	IN	OCC	IN	IN	OCC	IN	67%

DHCS REQUESTED PLAN OF CORRECTION FOR FINDINGS –ACCESS QUESTION 10

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.

MHP PLAN OF CORRECTION FOR ACCESS PROTOCOL QUESTIONS 9A and 10B

The Placer-Sierra County(s) MHP 24/7 toll-free number received eight (8) test calls as part of the triennial review. Of the eight test calls, six (75%) were rated as being out of compliance in one of the key areas. Five of the six test calls out of compliance were a result of not meeting the criteria as stated under protocol section 9a-2- requiring the 24/7 line to provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity; four of six (66%) calls were considered out of compliance for not meeting the criteria as stated under protocol section 9a-3-requiring the 24/7 line to provide information to beneficiaries about services needed to treat a beneficiary's condition; one of the six calls was deemed out of compliance for not providing information on how to use the beneficiary problem resolution and fair hearing process. Of the eight test calls, two of the six calls (33%) that were required to be logged (10b) were found to be out of compliance in all areas. The following plan of correction applies only to Placer County, as Sierra County's 24/7 test call was found to be in compliance in all areas.

MHP PLAN OF CORRECTION FOR ACCESS -9a and 10b.

- Amend *24/7 Annual Training* to include all areas of compliance ***(included in Appendix A).***
- Increase number of test calls from 10 annually to a minimum of 36.
- Develop a test call manual for individuals participating in the test calls that include more test call scrips that address all areas ***(included in Appendix A).***
- Continue to use monthly Survey for test callers to complete that includes all areas of compliance ***(included in Appendix A)***.
- Track monthly test calls and disseminate information to Intake Line supervisors and managers for review and course correction as needed (***Appendix B).***
- In addition, the Placer-Sierra County(s) MHP provides annual training to all employees and contracted employees on the proper procedure to follow when a caller is requesting routine mental health services that include non-emergency assessments, counseling, medication services, and other referrals. These procedures are outlined in *Adult Intake Services, Triaging a Crisis Call* ***(Appendix C)***.

SECTION G-PROVIDER RELATIONS

Provider Relations Question 2	**PROTOCOL REQUIREMENTS**
2	Regarding the MHP's ongoing monitoring of county-owned and operated and contracted organizational providers
2a	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?
2b	Is there evidence the MHP's monitoring system is effective?
CCR, title 9, chapter 11, section 1810.435 (d)I	*MHP Contract, Exhibit A, Attachment I*

DHCS FINDINGS-2b.

The MHP did not present evidence it has an ongoing and effective monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified per title 9 regulations. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 805: Site Certification and Physical Plant; Policy: Certification of Network and Org Providers; the MHP's bi-annual certification report; and a sample of provider certification results. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. DHCS reviewed its Online Provider System (OPS) just prior to the onsite review and generated an Overdue Provider Report which indicated the MHP had seven (7) providers overdue for certification and/or re-certification. The table below summarizes the report findings:

TOTAL ACTIVE PROVIDERS (PER OPS)	NUMBER OF OVERDUE PROVIDERS	COMPLIANCE PERCENTAGE
39	7	82%

Protocol question(s) G2b is deemed in partial compliance.

DHCS REQUESTED PLAN OF CORRECTION FOR PROVIDER RELATIONS -2b.

The MHP must submit a POC addressing the OCC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that is 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.

MHP PLAN OF CORRECTION FOR PROVIDER RELATIONS QUESTION #2b.

The MHP has been working diligently to ensure that site certifications are submitted within the expected time frames. The MHP has developed a *MH Site Certification Tracking Report* ***(Appendix D)*** that is reviewed during bi weekly compliance meetings. For the site certifications that the MHP "piggy backs" off of other Host Counties, the MHP has taken a proactive approach by notifying the Host County through a reminder that an organizational provider within their county's site certification will expire within 30 days. This communication and gentle prompting has allowed for the MHP to submit site certifications as soon as possible. One example of this communication with other host counties is included in ***Appendix E.*** Our most recent correspondence from DHCS has the MHP in full compliance with this requirement ***(Appendix F).*** As MHP must rely on both the Host County and DHCS to finish their processes for timely submission of the site certifications, this makes it extremely difficult for the MHP to remain 100% in compliance, especially when a certification is scheduled to expire at the end of the month. The MHP is respectfully requesting that DHCS revisits this process and considers adding a 30 day grace period for submission of the site certifications. For example: Host County's site certification expires on October 28th, the MHP would have until November 28th to have the site certification transmittal submitted and approved by DHCS. This change in practice would increase the compliance rates overall for the State.

Section I: QUALITY IMPROVEMENT

Quality Improvement question 6	**PROTOCOL REQUIREMENTS**
6.	Regarding the QM Work Plan:
6a.	Does the MHP have a QM Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed?
6b.	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?
6c.	Does the QM Work Plan include evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary services?
6d.	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.
6e.	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 routine appointments?
	3) Timeliness of services for urgent conditions?

	4) Access to after hour care?
6f.	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,* *DMH Information Notice No. 10-02, Enclosure, Page 23.*	*MHP Contract, Exhibit A, Attachment I* *CCR, title 9, section 1810.410* *CFR, title 42, Part 438 Managed care, sections438.204, 438.240 and 438.358.*

DHCS FINDINGS-6:

THE MHP presented evidence it has a QM/QI work plan covering the current contract cycle, with documented annual evaluations and necessary revision. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: 2015-2016 QM/QI Work plan. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, a goal for access to after-hours care was not documented in the work plan. Protocol Question(s) 6e4 is deemed OOC.

DHCS REQUESTED PLAN OF CORRECTION FOR QUALITY IMPROVMENT-6.

The MHP must submit a POC addressing the OOC Finding for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that is has a QM/QI Work plan covering the current contract cycle, with documented annual evaluations and necessary revisions, which meet MHP Contract requirements for all elements including question 16e4.

MHP PLAN OF CORRECTION FOR QUALITY IMPROVEMENT -6e4

For the last few years, the Placer-Sierra County MHP has assessed the accessibility of services within its service delivery area, including assessing the access to afterhours care; unfortunately, this has not been officially included in the QM work plan as a separate indicator. This has been achieved through tracking the *Adult Crisis Response Hospital Reviews-W&I 5150 Timeliness Data* ***(Appendix G***), *Mobile Crisis Timeliness Data* ***(Appendix H)*** and the *Follow Up Services Data* ***(Appendix I).*** Follow up services within the MHP are provided when staff contact individuals after they have requested services or when they have been seen in a local emergency room for a crisis that did not result in an involuntary detention. Assessing this area has been added to page 16 of the *Annual Quality Improvement Work Plan for* FY *2016-2017* ***(Appendix J).***

SECTION K-CLINICAL REVIEW FINDINGS

MEDICAL NECESSITY

	PROTOCOL REQUIREMENTS
1.	Does the beneficiary meet all three (3) of the following medical necessity criteria for reimbursement (1a, 1b, and 1c. below)?
1a.	The beneficiary has a current ICD diagnosis which is included for non-hospital SMHS in accordance with the MHP contract?
1b.	The beneficiary, as a result of a mental disorder or emotional disturbance listed in 1a, must have at least one (1) of the following criteria (1-4 below):
	1) A significant impairment in an important area of life functioning
	2) A probability of significant deterioration in an important area of life functioning
	3) A probability that the child will not progress developmentally as individually appropriate
	4) For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate.
1c.	Do the proposed and actual intervention(s) meet the criteria listed below:
	1) The focus of the proposed and actual intervention(s) is to address the condition identified in No. 1b (1-3) above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate per No. 1b(4).
	2) The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (A, B, C, or D):
	A. Significantly diminish the impairment
	B. Prevent significant deterioration in an important area of life functioning.
	C. Allow the child to progress developmentally as individually appropriate.
	D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.
1d.	The condition would not be responsive to physical health care based treatment.
CCR, title 9, chapter 11, section 1830.205(b)(c) *CCR, title 9, chapter 11, section 1830.210* *CCR, title 9, chapter 11, section 1810.345(c)* *CCR, title 9, chapter 11, section 1840.112(b)(1-4)*	*CCR, title 9, chapter 11, section 1840.314(d)* *CCR, title 22, chapter 3, section 51303(a)* *Credentialing Boards of MH Disciplines*

DHCS FINDINGS-1c-1

The medical record associated with the following Line numbers did not meet the medical necessity criteria since the focus of the proposed interventions did not address the mental health condition as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A):

- [redacted]. RR3, refer to Recoupment Summary for details.

DHCS REQUESTED PLAN OF CORRECTION FOR 1 c -1:

The MHP shall submit a POC that indicates how the MHP will ensure that interventions are focused on a significant functional impairment that is directly related to the mental health condition as specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(A).

DHCS FINDING 1c-2:
The medical record associated with the following Line numbers did not meet the medical necessity criteria since there was no expectation that the documented intervention would meet the intervention criteria as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(B)(1-4):

- [redacted]. RR4, refer to Recoupment Summary for details.

PLAN OF CORRECTION 1c-2:
The MHP shall submit a POC that indicates how the MHP will ensure that the interventions provided meet the intervention criteria specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(B)(1-4).

MHP PLAN OF CORRECTION FOR MEDICAL NECESSITY PROTOCOL QUESTIONS: 1c-1, 1c-2,

1830.205 (b) (3) (A) The focus of the proposed intervention is to address the condition identified in Subsection (b) (2) [Impairment is the result of a mental illness]

1830.205 (b)(3)(B)(1-4) the expectation of the proposed intervention will (1) significantly diminish the impairment , or 92) Prevent significant deterioration in an important area of life functioning, or (3) Except, as provided in section 1830.210 allow the child to progress developmentally as individually appropriate and (4) not be responsive to only physical health care.

The Placer/Sierra County(s) MHP requires all individuals billing Medi-Cal for SMHS to complete an annual training. Once a year, Network and Organizational providers are required to complete the annual *Mental Health Documentation, Auditing and Compliance Training* ***(Appendix K).*** County SMHS providers are required to complete the Annual Documentation and Billing Training ***(Appendix L)*** during the fall. The Network/Organizational Providers' *Mental Health Documentation, Auditing and Compliance Training* address these areas within slides #47-68 ***(Appendix K).*** Medical Necessity and Interventions are addressed throughout the *County's Documentation and Billing Training* (***Appendix L)***. These trainings are reviewed and updated by the Quality Assurance Team on an annual basis to ensure that new requirements are noted and areas where the MHP may be struggling are emphasized. Both of the annual trainings review the criteria for medical necessity and the development of the client plan, including thoroughly reviewing that the focus of the intervention must address the covered diagnoses, the expectation that the intervention will either significantly ameliorate the mental health condition of the client, or will prevent significant deterioration in an important are of life functioning. Medi-Cal rules around these issues are covered extensively as well. In addition to these annual trainings, the MHP Quality Assurance Team has revised audit tools including the *Supervisors Mental Health Chart Review Tool* (***Appendix M),*** and the Mental *Health Chart Review Tool for Lab* (***Appendix N)***. The MHP utilized the 2016 *Placer County Provider Audit Tool* ***(Appendix O)***, when conducting on site reviews of contracted providers. Conducting these on site reviews has been beneficial in identify challenging areas and provide ongoing support to providers to ensure ongoing compliance is adequate.

Both of the referenced documentation trainings have been revised once again with even stronger language in place to ensure clinicians address the client's condition in each and every note that is documented and billed for. In addition, the section of the training discussing non-billable activities has been enhanced with the actual notes (de-identified) from past DMH audit that were disallowed.

Results of all audits are reported to the Placer/Sierra Quality Improvement Committee on a quarterly basis. A summary of each of the various review/audit tools are listed below.

Supervisor Mental Health Chart Review Tool ***(Appendix M)***
Since the triennial review, the supervisors' tool has been created. This tool was designed to flow with the assessment, and provides compliance cues for the reviewer to be monitoring to as they approve or disapprove assessments. This tool is available to all supervisors and seniors that are reviewing and approving assessments.

Mental Health Chart Audit Tool (Lab) ***(Appendix N)***
The Mental Health Chart Audit tool is used to conduct a second type of audit, which is conducted by the supervisors and seniors. This type of audit and tool also has a section for determining that client plans and progress notes contain all the required elements. The Mental Health Chart Audit Tool (Lab) was created to assist staff, led by the Quality Improvement department, to review the compliance areas for a completed Assessment, Treatment Plan, and Progress Notes. All required elements of these documents are reviewed to ensure their compliance with all required areas. Once a month the supervisors and seniors receive the internal records for completing a peer review, the results of the peer review are discussed during the monthly lab. The QA leadership team facilitates the chart review lab with the goal of the lab being to build a stronger foundation and understanding of the information necessary to meet compliance standards for assessments.

Provider Audit Tool ***(Appendix O)***
This tool is used with both our individual network providers and Organizational Providers. The review tool explores compliance with authorization and charting requirements surrounding the Assessment, Client Plan, Progress Notes and Consents for Medications.

Providers (Network and Organizational Providers) receive an overview of the site review findings at the end of the on-site review along with a formal letter identifying the reviewing findings and any areas needing a plan of correction. Results of all internal and external utilization reviews are compiled into two reports, the *Placer County System of Care Network Provider Quarterly Utilization Review Report* ***(Appendix P)*** and the *Placer County Systems of Care Monthly Utilization Review Report for Mental Health Services* **(*Appendix Q*)*,*** and are disseminated directly after reviews or on quarterly basis. These reports are reviewed on a quarterly basis the Placer-Sierra Quality Improvement Committee on a quarterly basis, with areas of improvement and any decreases noted and ideas for improvement discussed. These results are also discussed at system of care supervisory meetings for further evaluation and implementation of plans for improvement. During reviews, if services are deemed to not be medically necessary or do not fall within the expected timelines or do not contain all required elements for Medi-Cal reimbursement, services are then "backed out" of the Medi-Cal system. For an example of the review process please refer to ***Appendix R*** *(confidential records submitted as back up support have been removed).* This appendix includes evidence of a complete MH review process, including notification of review, findings letter, plan of corrections, services backed out and acceptance letter of Plan of Correction.

In spite of a significant number of beneficiaries' that receive specialty mental health services directly from the County Mental Health Programs, 19 of the 20 (95%) clinical records randomly selected for this review during this triennial belonged to Organizational Providers. In addition to the annual documentation and billing trainings, and the QA onsite reviews with each of the organizational provider, the triennial review identified a need to increase monitoring of Organizational providers.

Renewed efforts to strengthen the MH Provider meetings occurred in the spring of 2016, resulting with a new Quarterly MH Provider meeting being established. During the September 30, 2016 MH provider meeting, the MHP QA Team reviewed the common causes of disallowances and the Triennial plans has reviewed the Triennial findings with our Individual and Organizational Providers during the September 30, 2016 quarterly MH Provider meeting *(please refer to **Appendix S** for meeting minutes)*. As an effort to increase providers compliance with Medi-Cal regulations, the MHP plans to review the new expectations related to clinical oversight to providers through the following steps with discussion of the items occurring at the the January 2017 MH Provider meeting.

1) Finalize notification to all MH Organizational Providers regarding quarterly reports ***(Appendix T)***
2) Finalize a MH Provider Attestation to include with Notification meetings ***(included in Appendix T)***
3) The QA team will be available to provide additional training as needed.

County Policies that address these areas include:

- Definition of Medical Necessity Policy ***(Appendix U)***
- Treatment Plan and Authorization Policy ***(Appendix V)***
- Initial and Updated Assessment Policy ***(Appendix W)***

ASSESSMENT

Protocol Requirements		
2.	Regarding the Assessment, are the following conditions met:	
2a.	1)	Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness?
	2)	Has the Assessment been completed in accordance with the MHP's established written documentation standards for frequency?
CCR, title 9, chapter 11, section 1810.204 *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* *CCR, title 9, chapter 11, section 1840.314(d)(e)*	*CCR, title 9, chapter 4, section 851 (LPS Act)* *MHP Contract, Exhibit A, Attachment 1*	

FINDINGS 2A:
Assessments were not completed in accordance with regulatory and contractual requirements, specifically:

One or more assessments were not completed within the timeliness and frequency requirements specified in the MHP's written documentation standards. The following details specific findings from the chart sample:

- [redacted] The initial assessment was completed late.
- [redacted]: The updated assessment was completed late.

PLAN OF CORRECTION 2A:
The MHP shall submit a POC that:

1) Indicates how the MHP will ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.

PROTOCOL REQUIREMENTS		
2b.	Do the Assessments include the areas specified in the MHP Contract with the Department?	
	1)	Presenting Problem. The beneficiary's chief complaint, history of presenting problem(s) including current level of functioning, relevant family history and current family information;
	2)	Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health including, as applicable; living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma;
	3)	Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data such as previous mental health records and relevant psychological testing or consultation reports;
	4)	Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.
	5)	Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment must include documentation of the absence or presence of allergies or adverse reactions to medications and documentation of an informed consent for medications;

	6)	Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (Complementary and alternative medications) and over the counter drugs and illicit drugs:
	7)	Client strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
	8)	Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma:
	9)	A mental status examination:
	10)	A Complete Diagnosis; A diagnosis from the current ICD –Code must be documented, consistent with the representing problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.

CCR, title 9, chapter 11, section 1810.204 *CCR, title 9, chapter 11, section 1840.112 (b) (1-4)* *CCR, title 9, chapter 11, section 1840.314 (d) (e)*	*CCR, title 9, chapter 4, section 851-LPS Act* *MHP Contract, Exhibit A, Attachment 1*

DHCS FINDING 2B:

One or more of the assessments reviewed did not include all of the elements specified in the MHP Contract with the Department. The following required elements were incomplete or missing:

7) Client Strengths:
8) Risks:

DHCS REQUESTED PLAN OF CORRECTION ON 2b:

The MHP shall submit a POC that indicates how the MHP will ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department.

MHP CORRECTIVE ACTION PLAN FOR OUT OF COMPLIANCE-ASSESSMENT-2a and 2b

The Placer/Sierra MHP will ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards through the following steps:

- Revising annual trainings ***(Appendix J, Appendix K)***. The MHP operates from a recovery and strength based service delivery system. The annual documentation training is built upon this premise and foundation that all services, should be delivered in a collaborative, client centered, strength based approach. As a result of the findings during this triennial review, the annual trainings have been reviewed to include clearer guidance related to the documentation of client's strengths and risk identified through the assessment process. This training has been enhanced to have clinician's identify the individual client's strengths that are relevant to their ability to achieve identified goals. Clinicians are encouraged to work with the client to incorporate individual strengths to address the identified impairments. In addition, the documentation training expands the areas that may post to be a risk for the client, not only in the areas of harm to self or others but also in the area of relapse/decompensation. Both County and Network/Organizational Provider annual trainings will occur by the end of each calendar year(December 31, 2016 for this POC).
- Compliance monitoring tool, includes verifying client's strengths and risk are addressed.
- Facilitate monthly meetings with all County MH Supervisors and seniors to increase skills set necessary to ensure compliance.
- Continue with internal and external chart review to monitor adherence.

- MHP requires that Supervisors and/or seniors review assessments to ensure compliance and track timeliness.
- During the past year, case load reports within the AVATAR Electronic health record were developed that would allow both supervisors and direct service provider to review their case loads. This report , known as the *AVATAR Client Directory by Attending Practitioner Report,* includes pertinent information including assessment and treatment plan due dates, last date of service by non MD and last day of services by prescriber ***(Appendix X).***

As previously mentioned, when the MHP determines that services were inaccurately billed (not medically necessary, do not adhere to timelines, lack of required elements) services are either converted to non-billable or if charges have been submitted for reimbursement, the services are "backed out" using the *Placer County System of Care Accounting Notice* ***(Appendix Y)*** .

Medication Consent

PROTOCOL REQUIREMENTS	
3	Regarding medication consent forms:
3a	Did the provider obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication?
CCR, title 9, chapter 11, section 1810.204 *CCR, title 9, chapter 11, section 1840.112 (b) (1-4)* *CCR, title 9, chapter 11, section 1840.314 (d) (e)*	CCR, title 9, chapter 4, section 851-LPS Act MHP Contract, Exhibit A, Attachment 1

DHCS FINDING 3a
The provider did not obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication.

- [redacted]: There was no written medication consent form found in the medical record. *During the review, MHP staff was given the opportunity to locate the missing medication consent form but was unable to locate it in the medical record.*

DHCS REQUESTED PLAN OF CORRECTION 3A:
The MHP shall submit a POC that indicates how the MHP will ensure that:

1) A written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP.
2) Written consent forms are completed in accordance with the MHP's written documentation standards**.**

PROTOCOL REQUIREMENTS		
3B.	Does the medication consent for psychiatric medications include the following required elements?	
	1)	The reason for taking the medications?
	2)	Reasonable alternative treatments available, if any?
	3)	Type of medication?
	4)	Range of frequency (of administration)?
	5)	Dosage
	6)	Method of Administration?
	7)	Duration of taking the medication?
	8)	Probably side effects?
	9)	Possible side effects if taken longer than 3 months?
	10)	Consent once given may be withdrawn at any time?

CCR, title 9, chapter 11, section 1810.204	*CCR, title 9, chapter 4, section 851-LPS Act*
CCR, title 9, chapter 11, section 1840.112 (b) (1-4)	*MHP Contract, Exhibit A, Attachment 1*
CCR, title 9, chapter 11, section 1840.314 (d) (e)	

DHCS FINDINGS 3b:

Written medication consents did not contain all of the required elements specified in the MHP Contract with the Department. The following required elements were not documented on the medication consent forms found in the beneficiary's medical record:

1) Reason for taking each medication: [redacted]
2) Reasonable alternative treatments available, if any: [redacted].
3) Type of medication: [redacted].
4) Range of frequency: [redacted].
5) Dosage: [redacted]
6) Method of administration (oral or injection): [redacted].
7) Duration of taking each medication: [redacted].
8) Probable side effects: [redacted].
9) Possible side effects if taken longer than 3 months: [redacted] and [redacted].
10) Consent once given may be withdrawn at any time: [redacted]

DHCS REQUESTED PLAN OF CORRECTION ON 3B:

The MHP shall submit a POC that indicates how the MHP will ensure that every medication consent includes documentation of all of the required elements specified in the MHP Contract with the Department.

MHP CORRECTIVE ACTION PLAN FOR OUT OF COMPLIANCE-MEDICATION CONSENTS-3a and 3b

The MHP will address the out of compliance areas related to the Medication Consents by the following steps:

1) Revised medication consent form ***(Appendix Z)***.
2) Request all contracted organizational providers either utilize the MHP Medication Consent or ensure the required elements are included within their Medication Consents and demonstrate review of clinical documentations through Quarterly QI Reports ***(included in Appendix T)).***
3) MH provider attestation has been created and disseminated to providers to strengthen their understanding of their responsibilities and compliance requirements ***(Appendix T).***
4) In accordance to our standard of practice, Prescribers will continue to provide clients with medication facts forms.

CLIENT PLANS

PROTOCOL REQUIREMENTS		
4	Regarding the client plan, are the following conditions met:	
4a	1)	Has the initial client plan been completed within the time period specified in the Mental Health Plan (MHP's) documentation guidelines, or lacking MHP guidelines, within 60 days of the intake unless there is documentation supporting the need for more time?
CCR, title 9, chapter 11, section 1810.205.2 *CCR, title 9, chapter 11, section 1810.254* *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* *CCR, title 9, chapter 11, section 1840.314(d)(e)*		*DMH Letter 02-01, Enclosure A* *WIC, section 5751.2* *MHP Contract, Exhibit A, Attachment I* *CCR, title 16, Section 1820.5* *California Business and Profession Code, Section 4999.2*

DHCS FINDINGS 4A-1

The initial client plan was not completed within the time period specified in the MHP's documentation standards, or lacking MHP standards, not within 60 days of the intake, with no evidence supporting the need for more time.

- [REDACTED]: There was no initial client plan for one type of service being claimed. During the review, MHP staff was given the opportunity to locate the service in question on a client plan that was effective during the claim period but could not find written evidence of it. RRS, refer to Recoupment Summary for details

  The MHP should review all services and claims during which there was no client plan for the services in question and disallow those claims as required.

DHCS REQUESTED PLAN FOR CORRECTION 4a-1:

The MHP shall submit a POC that indicates how the MHP will ensure that:

1) Initial client plans are completed in accordance with the MHP's written documentation standards.
2) All types of interventions/service modalities provided and claimed are recorded as proposed interventions on a current client plan.
3) The interventions/modalities on all client plans are clear, specific and address the beneficiary's identified functional impairments as a result of the mental disorder.

PROTOCOL REQUIREMENTS		
4A	2)	Has the client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition?
CCR, title 9, chapter 11, section 1810.205.2 *CCR, title 9, chapter 11, section 1810.254* *CCR, title 9, chapter 11, section 1810.440(c)(1){2)* *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* *CCR, title 9, chapter 11, section 1840.314(d)(e)*		*DMH Letter 02-01, Enclosure A* *WIC, section 5751.2* *MHP Contract, Exhibit A, Attachment I* *CCR, title 16, Section 1820.5* *California Business and Profession Code, Section 4999.20*

DHCS FINDING 4a-2:

The client plan was not updated at least annually or when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department):

: There was a lapse between the prior and current client plans. However, this occurred outside of the audit review period.
The MHP should review all services and claims outside of the audit review period during which there was no client plan in effect and disallow those claims as required.
: The medical record indicated that the beneficiary was hospitalized during the effective period of the client plan; however, there was no evidence that the client plan was reviewed and/or updated in response to this event.

DHCS REQUESTED PLAN OF CORRECTION FOR 4a-2:
The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that client plans are completed at least on an annual basis as required in the MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.
2) Ensure that non-emergency services are not claimed when:
    a. A client plan has not been completed.
    b. The service provided is not included in the current client plan.
3) Provide evidence that all services identified during the audit that were claimed outside of the audit review period for which no client plan was in effect are disallowed.
4) Client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.

PROTOCOL REQUIREMENTS		
4b.	Does the client plan include the items specified in the MHP Contract with the Department?	
	1)	Specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.
	2)	The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.
	3)	The proposed frequency of intervention(s).
	4)	The proposed duration of intervention(s).
	5)	interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance
	6)	interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance
	7)	Be consistent with the qualifying diagnoses.
CCR, title 9, chapter 11, section 1810.205.2 *CCR, title 9, chapter 11, section 1810.254* *CCR, title 9, chapter 11, section 1810.440(c)(1}(2)* *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* *CCR, title 9, chapter 11, section 1840.314(d)(e)*		*DMH Letter 02-01, Enclosure A* *WIC, section 5751.2* *MHP Contract, Exhibit A Attachment I* *CCR, title 16, Section 1820.5* *California Business and Profession Code, Section 4999.20*

DHCS FINDING 4b.
The following Line numbers had client plans that did not include all of the items specified in the MHP Contract with the Department:

4b-1) One or more of the goals/treatment objectives were not specific, observable, and/or

quantifiable and related to the beneficiary's mental health needs and identified functional impairments as a result of the mental health diagnosis. [redacted] and [redacted]

4b-2) One or more of the proposed interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded on the client plan (e.g. "Medication Support Services," "Targeted Case Management," "Mental Health Services," etc.). [redacted]

4b-3) One or more of the proposed interventions did not indicate an expected frequency. [redacted]

4b-4) One or more of the proposed interventions did not indicate an expected duration. [redacted]

4b-7) One client plan contained one or more proposed interventions that were not consistent with the qualifying diagnosis. [redacted]

DHCS REQUESTED PLAN OF CORRECTION 4b:

The MHP shall submit a POC that indicates how the MHP will ensure that:

1) All client plan goals/treatment objectives are specific, observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis.
2) All mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or modality of service (e.g. "therapy", "medication", "case management", etc.).
3) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.
4) All client plans are consistent with the qualifying diagnosis.

PROTOCOL REQUIREMENTS	
4C. Is the client plan signed (or electronic equivalent) by:	
1) The person providing the service(s) or,	
2) A person representing a team or program providing the service(s) or,	
3) A person representing the MHP providing service(s) or,	
4) By one of the following, as a co-signer, if the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is not of the approved categories, one (1) of the following must sign:	
A. A Physician	
B. Licensed/Registered/Waivered Psychologist	
C. Licensed/Registered/Waivered Social Worker	
D. Licensed/Registered/Waivered Marriage and Family Therapist	
E. Licensed/Registered/Waivered Professional Clinical Counselor*	
F. A Registered Nurse including but not limited to nurse practitioners, and clinical nurse specialist.	
CCR, title 9, chapter 11, section 1810.205.2	*DMH Letter 02-01, Enclosure A*
CCR, title 9, chapter 11, section 1810.254	*WIC, section 5751.2*
CCR, title 9, chapter 11, section 1810.440(c)(1)(2)	*MHP Contract, Exhibit A, Attachment I*
CCR, title 9, chapter 11, section 1840.112(b)(2-5)	*CCR, title 16, Section 1820.5*
CCR, title 9, chapter 11, section 1840.314(d)(e)	*California Business and Profession Code, Section 4999.20*

DHCS FINDING 4C:

The MHP did not furnish evidence it has written documentation standards for staff signatures. The client plan was not signed (or electronic equivalent) by the appropriate staff as specified in the MHP Contract and CCR, Title 9, Chapter 11, section 1810.440 (c) (1) (A-C):

- [redacted]: The client plan was not signed or co-signed (or electronic equivalent) by an approved category of staff until after the effective start date of the client plan.

DHCS REQUESTED PLAN OF CORRECTION FOR 4c:

The MHP shall submit a POC that indicates how the MHP will ensure that:

1) The signature or co-signature of an approved category of staff is obtained when required as specified in the MHP Contract.
2) The signature of the appropriate staff is timely

PROTOCOL REQUIREMENTS	
4e. Is there documentation that the contractor offered a copy of the client plan to the beneficiary?	
CCR, title 9, chapter 11, section 1810.205.2	*DMH Letter 02-01, Enclosure A WIC, section 5751.2*
CCR, title 9, chapter 11, section 1810.254	*MHP Contract, Exhibit A, Attachment I*
CCR, title 9, chapter 11, section 1810.440(c)(1)(2)	*CCR, title 16, Section 1820.5*
CCR, title 9, chapter 11, section 1840.112(b)(2-5)	*California Business and Profession Code, Section 4999.20*
CCR, title 9, chapter 11, section 1840.314(d)(e)	

DHCS FINDINGS 4e.

There was inadequate or missing documentation that the beneficiary or legal guardian was offered a copy of the client plan for the following: [redacted]

DHCS REQUESTED PLAN OF CORRECTION FOR 4e.

The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that there is documentation substantiating that the beneficiary was offered a copy of the client plan.
2) Submit evidence that the MHP has an established process to ensure that the beneficiary is offered a copy of the client plan and whether or not he/she received a copy of the client plan.

MHP PLAN OF CORRECTION FOR SECTION J-CLIENT PLANS-4a, 4a-2, 4b, 4c, 4e.

In spite of Placer-Sierra County(s) MHP QA programs due diligence in providing clinical oversight and training to ensure that all Medi-Cal requirements are clearly documented within beneficiary's records, a 100% review of all documentation is not completed. Placer-Sierra County(s) MHP Quality Assurance Program has historically set an auditing goal in the Quality Management Plan which exceeded the expected 5% review of clinical documentations as outlined in the MHP Contract with DHCS. This number has ranged from 33% to 80% depending on the year and program. In general, determination of reviewing organizational and network providers is based on the number of beneficiaries receiving services and the amount of services being provided by the organization or network provider.

County operated MH programs within the MHP (Anasazi for Sierra County and AVATAR for Placer County) have safe guards in place to ensure that compliance elements are addressed and go through a secondary level review before finalizing the treatment plans. A significant number of beneficiaries' that receive specialty mental health services directly from the County Mental Health Programs, 19 of the 20 (95%) clinical records randomly selected for this review during this triennial belonged to Organizational Providers.

- The County's annual documentation and billing trainings for county, organizational and network providers clearly identify all required elements of the client plan. These trainings review the required timelines for completing treatment plans, client/legal guardian signature or documentation of participation in the development of treatment plan requirement of client. Enhancement to these annual trainings included the expectation that treatment plans will be reviewed and updated as necessary when clinically indicated but no less than annually. Several slides in this training discuss treatment goals being measurable with more specific interventions including duration, frequency and who is responsible for each intervention that is focused on the impairments as a result of symptoms of the individual's diagnosis. Both County and Network/Organizational Provider annual trainings will occur by the end of each calendar year (December 31, 2016 for this POC).

In addition to the annual documentation and billing trainings, and the QA onsite reviews with each of the organizational provider, the triennial review identified a need to increase monitoring of Organizational providers. Renewed efforts to strengthen the MH Provider meetings occurred in the spring of 2016, resulting with a new Quarterly MH Provider meeting being established. During the September 30, 2016 MH provider meeting, the MHP QA Team reviewed the common causes of disallowances and the Triennial plans has reviewed the Triennial findings with our Individual and Organizational Providers during the September 30, 2016 quarterly MH Provider meeting (please refer to Appendix R for meeting minutes). The MHP plans to implement the following steps by December 31, 2016.

1) Finalize notification to all MH Organizational Providers regarding quarterly reports ***(Appendix T)***
2) Finalize a MH Provider Attestation to include with Notification meetings ***(Appendix T)***
3) The QA team will be available to provide additional training as needed.
4) The MHP will offer to share their internal review tools with MH providers to assist with Providers internal monitoring that compliance issues are being reviewed and addressed appropriately **(Appendix M, Appendix N, Appendix O).**

PROGRESS NOTES

PROTOCOL REQUIREMENTS		
5a.	Do the progress notes document the following:	
	1)	Timely documentation (as determined by the MHP) of relevant aspects of client care, including documentation of medical necessity?
	2)	Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions?
	3)	Interventions applied beneficiary's response to the interventions, and the location of the interventions?
	4)	The date the services were provided?
	5)	Documentation of referrals to community resources and other agencies, when appropriate?
	6)	Documentation of follow-up care or, as appropriate, a discharge summary?
	7)	The amount of time taken to provide services?
	8)	The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?
CCR, title 9, chapter 11, section 1810.254 *CCR, title 9, chapter 11, section 1810.440(c)* *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* *CCR, title 9, chapter 11, section 1840.314*		*CCR, title 9, chapter 11, sections 1840.316 - 1840.322* *CCR, title 22, chapter 3, section 51458. 1* *CCR, title 22, chapter 3, section 51470* *MHP Contract, Exhibit A, Attachment I*

DHCS FINDINGS 5a.

Progress notes were not completed in accordance with regulatory and contractual requirements and/or with the MHP's own written documentation standards:

- 5a-1) [redacted]: Timely documentation of relevant aspects of beneficiary care as specified by the MHP's documentation standards (i.e., progress notes completed late based on the MHP's written documentation standards in effect during the audit period).
- 5a-2) [redacted] Beneficiary encounters, including relevant clinical decisions, when decisions are made and alternative approaches for future interventions, were not clear on one or more progress notes.
- 5a-4) [redacted]: Timeliness of the progress note could not be determined because the note was signed but not dated by the person providing the service. Therefore, the progress note was considered as late since the date the progress note was entered into the medical record could not be determined.
- 5a-8) [redacted] The provider's professional degree, licensure or job title.

- Appointment was missed or cancelled: [redacted]. RR19a, refer to Recoupment Summary for Details.

PLEASE NOTE: The exact same verbiage was recorded on multiple progress notes, and therefore those progress notes were not individualized, did not accurately document the beneficiary's response and the specific interventions applied, as specified in the MHP Contract with the Department for: [redacted]

DHCS REQUESTED PLAN OF CORRECTION

The MHP shall submit a POC that indicates how the MHP will:

1) Describe how the MHP will ensure that progress notes are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.
2) The MHP shall submit a POC that indicates how the MHP will ensure that progress notes document:
   - 5a-1) Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and the MHP's written documentation standards.
   - 5a-2) Relevant clinical decisions, when decisions are made, and alternative approaches for future interventions, as specified in the MHP Contract with the Department.
   - 5a-4) The date the progress note was completed and entered into the medical record by the person(s) providing the service in order to determine the timeliness of completion, as specified in the MHP Contract with the Department.
   - 5a-8) The provider's/providers' professional degree, licensure or job title.
3) The documentation is individualized for each service provided.
4) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a) (b).

DHCS FINDINGS 5a-3:

The following Line numbers had documentation indicating a Specialty Mental Health Service (SMHS) was provided while the beneficiary resided in a setting that was ineligible for Federal Financial Participation or when the beneficiary was served in a setting subject to lockouts:

- Service was provided while the beneficiary resided in an Institute for Mental Disease. [redacted]. RR11, refer to Recoupment Summary for details.

The progress note(s) for the following Line numbers indicate that the service provided was solely for:

- Clerical: [redacted]. RR17, refer to Recoupment Summary for details.
- Payee related: [redacted]. RR18, refer to Recoupment Summary for details.

DHCS REQUEST PLAN OF CORRECTION FOR 5a-3:
The MHP shall submit a POC that indicates how the MHP will ensure that:

1) Services claimed were provided in a setting where the beneficiary was eligible for FFP or not subject to lockouts.
2) Each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning, as outlined in the client plan.
3) Services provided and claimed are not solely transportation, clerical or payee related.
4) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a) (b).

PROTOCOL REQUIREMENTS	
5c. Timeliness/frequency as follows:	
1) Every service contact for:	
A. Mental health services	
B. Medication support services	
C. Crisis intervention	
D. Targeted Case Management	
2) Daily for:	
A. Crisis residential	
B. Crisis stabilization (one per 23/hour period)	
C. Day treatment intensive	
3) Weekly for:	
A. Day treatment intensive {clinical summary)	
B. Day rehabilitation	
C. Adult residential	
CCR, title 9, chapter 11, section 1810.254 *CCR, title 9, chapter 11, section 1810.440(c)* *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* *CCR, title 9, chapter 11, section 1840.314*	*CCR, title 9, chapter 11, sections 1840.316 - 1840.322* *CCR, title 22, chapter 3, section 51458. 1* *CCR, title 22, chapter 3, section 51470* *MHP Contract, Exhibit A, Attachment I*

DHCS FINDINGS 5c:
Documentation in the medical record did not meet the following requirements:

- [redacted]: The type of specialty mental health service (SMHS) documented on the progress note was not the same type of SMHS claimed. RR9, refer to Recoupment Summary for details.

DHCS REQUESTED PLAN OF CORRECTION FOR 5c:

The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that all SMHS claimed are:
    a. Actually provided to the beneficiary.
    b. Appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205{a)(b).
    c. Claimed for the correct service modality and billing code.
2) Ensure that all progress notes are:
    a. Accurate and meet the documentation requirements described in the MHP Contract with the Department.

PROTOCOL REQUIREMENTS	
5d. Do all entries in the beneficiary's medical record include:	
1) The date of service?	
2) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?	
3) The date the documentation was entered in the medical record?	
CCR, title 9, chapter 11, section 1810.254 *CCR, title 9, chapter 11, section 1810.440(c)* *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* *CCR, title 9, chapter 11, section 1840.314*	*CCR, title 9, chapter 11, sections 1840.316 - 1840.322* *CCR, title 22, chapter 3, section 51458. 1* *CCR, title 22, chapter 3, section 51470* *MHP Contract, Exhibit A, Attachment I*

DHCS FINDINGS 5d.

The Progress notes did not include:

- Signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, or job title: [redacted]
- The following Line # had a progress note indicating that the documented and claimed service provided was not within the scope of practice of the person delivering the service: [redacted]. RR19d, refer to Recoupment Summary for details.

  The MHP should review all services and claims provided by the staff who was not qualified and disallow the claims as required.
- Date the documentation was entered into the medical record: [redacted]

DHCS REQUESTED PLAN OF CORRECTION FOR 5d:

The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that all documentation includes the signature or (electronic equivalent) with the professional degree, licensure or title of the person providing the service.
2) Ensure that all documentation includes the date the signature was completed and the document was entered into the medical record.
3) Ensure all services claimed are provided by the appropriate and qualified staff within his or her scope of practice, if professional licensure is required for the service.
4) Ensure that staff adheres to the MHP's written documentation standards and policies and procedures for providing services within the staff's scope of practice.
5) Ensure that services are not claimed when services are provided by staff outside the staff's scope of practice or qualifications.
6) Provide evidence that all claims in which the staff was not qualified to provide services were disallowed

MHP PLAN OF CORRECTION FOR Section J-PROGRESS NOTES-5a-1, 5a-2, 5a-3, 5a-4, 5a-8, 5c , 5d.

As discussed throughout the Placer-Sierra County(s) MHP Plan of Correction for DHCS System Review, the MHP requires that all individuals billing Medi-Cal for SMHS complete an Annual training on Documentation and Billing ***(Appendix J and Appendix K)*** and pass the post test. This training outlines what services are billable and how services are to be claimed. The training also outlines what types of services are not billable to Medi-Cal. This Annual training and various policies (Unified Service Plan- ***Appendix V***, Assessment policy –***Appendix W***) discuss the time frames for initial services including the information that services may not be billed after 60 days of initial request unless an assessment and treatment plan have been completed.

In spite of Placer-Sierra County(s) MHP QA programs due diligence in providing clinical oversight and training to ensure that all Medi-Cal requirements are clearly documented within beneficiary's records, a 100% review of all documentation is not completed. Placer-Sierra County(s) MHP Quality Assurance Program has historically set an auditing goal in the Quality Management Plan which exceeded the expected 5% review of clinical documentations as outlined in the MHP Contract with DHCS. This number has ranged from 33% to 80% depending on the year and program. In general, determination of reviewing organizational and network providers is based on the number of beneficiaries receiving services and the amount of services being provided by the organization or network provider

County operated MH programs within the MHP (Anasazi for Sierra County and AVATAR for Placer County) have safe guards in place to ensure that compliance elements are addressed and go through a secondary level review before finalizing the treatment plans. A significant number of beneficiaries' that receive specialty mental health services directly from the County Mental Health Programs, 19 of the 20 (95%) clinical records randomly selected for this review during this triennial belonged to Organizational Providers resulting in 99% of the progress notes being reviewed were completed by providers.

As previously discussed in this POC , in addition to the annual documentation and billing trainings, and the QA onsite reviews with each of the organizational provider, the triennial review identified a need to increase monitoring of Organizational providers. Renewed efforts to strengthen the MH Provider meetings occurred in spring of 2016, resulting with a new Quarterly MH Provider meeting being established. During the September 30, 2016 MH provider meeting, the MHP QA Team reviewed the common causes of disallowances and the Triennial plans has reviewed the Triennial findings with our Individual and Organizational Providers during the September 30, 2016 quarterly MH Provider meeting (please refer to **Appendix R** for meeting minutes). The MHP plans to implement the following steps by December 31, 2016.

1) Finalize notification to all MH Organizational Providers regarding quarterly reports ***(Appendix T)***
2) Finalize a MH Provider Attestation to include with Notification meetings ***(included in Appendix T)***
3) The QA team will be available to provide additional training as needed.
4). The MHP will offer to share their internal review tools with MH providers to assist with Providers internal monitoring that compliance issues are being reviewed and addressed appropriately **(Appendix M, Appendix N, Appendix O).**

SERVICE COMPONENTS FOR DAY TREATMENT INTENSIVE AND DAY REHABILITATION PROGRAMS

PROTOCOL REQUIREMENTS	
7a.	Regarding Service Components for Day Treatment Intensive and Day Rehabilitation programs:
	1) Do Day Treatment Intensive and Day Rehabilitation programs include all the following required service components:
	A. Daily Community Meetings;*
	B. Process Groups;
	C. Skill-building Groups; and
	D. Adjunctive Therapies?
	2) Does Day Treatment Intensive Include Psychotherapy?
CCR, title 9, chapter 11, section 1810.212 *CCR, title 9, chapter 11, section 1810.213* *CCR, title 9, chapter 11, section 1840.112(b)* *CCR, title 9, chapter 11, section 1840.314(d)(e)*	*CCR, title 9, chapter 11, section 1840.318* *CCR, title 9, chapter 11, section 1840.360* *MHP Contract, Exhibit A, Attachment I* *DMH Letter No. 03-03*

DHCS FINDINGS 7a:

Documentation for the following Line numbers indicated the required service components for both Day Rehabilitation and Day Treatment Intensive programs were not included, as specified by the MHP Contract with the Department:

- [redacted] Both Day Treatment Intensive and Day Rehabilitation programs did not include all required service components. RR9, refer to Recoupment Summary for details.

DHCS REQUESTED PLAN OF CORRECTION FOR 7a:

The MHP shall submit a POC that indicates how the MHP will ensure that all program requirements for both Day Rehabilitation and Day Treatment Intensive are provided in accordance with regulatory and contractual requirements. For example:

1) Ensure that all the required service components, including process groups, are clearly documented as being provided.
2) Ensure that the community meetings occur at least once a day.
3) Ensure that all Day Rehabilitation and Day Treatment Intensive services claimed were actually provided to the beneficiary as specified in the MHP Contract.

PROTOCOL REQUIREMENTS	
7b.	Regarding Attendance
	1) Is there documentation of the total number of minutes/hours the beneficiary actually attended the program?
	2) If the beneficiary is unavoidably absent:
	A. Is the total time (number of hours and minutes) the beneficiary actually attended the program that day documented;
	B. Is the beneficiary present for at least 50 percent of the scheduled hours of operation for that day; AND,
	C. Is there a separate entry in the medical record documenting the reason for the unavoidable absence?
CCR, title 9, chapter 11, section 1810.212 *CCR, title 9, chapter 11, section 1810.213* *CCR, title 9, chapter 11, section 1840.112(b)* *CCR, title 9, chapter 11, section 1840.314(d)(e)*	*CCR, title 9, chapter 11, section 1840.318* *CCR, title 9, chapter 11, section 1840.360* *MHP Contract, Exhibit A, Attachment I* *DMH Letter No. 03-03*

DHCS FINDINGS-7b:

Documentation for the following Line numbers indicated that essential requirements for Day Rehabilitation programs were not met, as specified by the MHP Contract with the Department:

- [redacted]: Day Rehabilitation services were claimed when the beneficiary was absent or was not present for the minimum amount of time to be claimed. The MHP should review all beneficiaries' past services and claims for these providers (provider #s [redacted]) to determine if billing was appropriate and disallow those claims that were not correctly billed. RR10, refer to Recoupment Summary for details.

DHCS REQUESTED PLAN OF CORRECTION FOR 7b:

1) Ensure that the total number of minutes/hours each beneficiary actually attends a *Day Rehabilitation* or *Day Treatment Intensive* program are documented for each day of attendance.
2) Ensure that when the beneficiary is unavoidably absent, that the total time (number of minutes and hours) the beneficiary actually attended the program that day is documented; and that the beneficiary is present for at least 50 percent of the scheduled hours of operation for that day; and there is a separate entry in the medical record documenting the reason for the unavoidable absence provided in order to claim for *Day Rehabilitation* or *Day Treatment Intensive* programs.
3) Ensure that all *Day Rehabilitation* and *Day Treatment Intensive* services claimed were actually provided to the beneficiary as specified in the MHP Contract.

PROTOCOL REQUIREMENTS	
7C. Regarding Continuous Hours of Operation:	
1) Did the provider apply the following when claiming for the continuous hours of operation of Day Treatment Intensive and Day Rehabilitation services?	
A. For Half Day: The beneficiary received face to face services a minimum of three (3) hours each day the program was open.	
B. For Full Day: The beneficiary received face to face services in a program with services available more than four (4) hours per day.	
CCR, title 9, chapter 11, section 1810.212 *CCR, title 9, chapter 11, section 1810.213* *CCR, title 9, chapter 11, section 1840.112(b)* *CCR, title 9, chapter 11, section 1840.314(d)(e)*	*CCR, title 9, chapter 11, section 1840.318* *CCR, title 9, chapter 11, section 1840.360* *MHP Contract, Exhibit A, Attachment I* *DMH Letter No. 03-03*

DHCS FINDINGS-7c:

Documentation for the following Line number indicated that essential requirements for a Day Rehabilitation program were not met, as specified by the MHP Contract with the Department:

- [redacted]: The beneficiary did not receive the minimum required hours in order to claim for a full day of Day Rehabilitation services. RR10, refer to Recoupment Summary for details.

DHCS REQUESTED PLAN OF CORRECTION FOR 7c:

1) Ensure that Day Rehabilitation services are claimed only when the beneficiary attends the minimum amount of time required for the service claimed.

PROTOCOL REQUIREMENTS	
7f. Regarding the Written Program Description:	
1) Is there a Written Program Description for *Day Treatment Intensive* and *Day Rehabilitation*?	
A. Does the Written Program Description describe the specific activities of each service and reflect each of the required components of the services as described in the MHP Contract.	
2) Is there a Mental Health Crisis Protocol?	
3) Is there a Written Weekly Schedule?	
A. Does the Written Weekly Schedule:	
a. Identify when and where the service components will be provided and by whom: and	
b. Specify the program staff, their qualifications, and the scope of their services?	
CCR, title 9, chapter 11, section 1810.212	*CCR, title 9, chapter 11, section 1840.318*
CCR, title 9, chapter 11, section 1810.213	*CCR, title 9, chapter 11, section 1840.360*
CCR, title 9, chapter 11, section 1840.112(b)	*MHP Contract, Exhibit A, Attachment I*
CCR, title 9, chapter 11, section 1840.314(d)(e)	*DMH Letter No. 03-03*

DHCS FINDINGS-7f-1:
The Written Program Description for both Day Rehabilitation did not clearly reflect all required service components - as described in the MHP Contract - for the following: [REDACTED]

DHCS REQUESTED PLAN OF CORRECTION FOR 7f-1:
The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that the Written Program Description for the MHP's contracted Day Treatment Intensive and Day Rehabilitation programs describe the specific activities of each service and clearly reflect each of the service components required in the MHP Contract.
2) Provide evidence that there is a full and complete Written Program Description for any Day Treatment Intensive and Day Rehabilitation program under contract with, or provided by, the MHP.

DHCS FINDINGS-7f-3:
The Written Weekly Schedules for both Day Treatment Intensive/Day and Day Rehabilitation programs did not clearly identify:

- [REDACTED]: All required service components.

DHCS REQUESTED PLAN OF CORRECTION FOR 7f3:
The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that there is a Written Weekly Schedule for all *Day Treatment Intensive* and *Day Rehabilitation* programs that clearly includes all required service components.
2) Ensure that the Written Weekly Schedule for *all Day Treatment Intensive* and *Day Rehabilitation* programs identifies when and where the service components will be provided and by whom;
3) Ensure that the Written Weekly Schedule for all *Day Treatment Intensive* and *Day Rehabilitation* programs identifies the program staff and specifies their qualifications and scope of their services.
4) Provide evidence that there is a current Written Weekly Schedule for all *Day Treatment Intensive* and *Day Rehabilitation programs* that is updated whenever there is any change in program staff and/or schedule.

MHP PLAN OF CORRECTION-SECTION J-DAY INTENSIVE AND DAY REHABILITATION PROGRAMS-7A, 7B, 7C, AND 7F.

The MHP was found to be out of compliance in five areas of the Specialty Mental Health Triennial Protocol related to *Day Rehabilitation Services* and *Day Intensive Services*. Recently, throughout the State of California, many providers of these services have transitioned to providing these services through an unbundled format rather than bundled. In consideration of the MHP Plan of Correction for these compliance issues, it should be noted that many of the areas found to be Out of Compliance through a bundled service, would no longer be found as such when the provider unbundled.

Currently, the MHP has only one provider that has not made the decision to unbundle their services. In addition, taking into account the impact of the Continuum of Care Reform, the MHP would ensure increase compliance with the protocol areas found to be deficient through:

1. Request providers to submit quarterly QI Reports that demonstrate internal monitoring and identification of compliance with required state, federal and contractual obligations ***(Appendix T).***
2. Require providers to submit weekly schedules to MHP on a quarterly basis with QI Reports and MH Provider Attestation ***(Appendix T).***
3. MHP to continue to facilitate a minimum of annual reviews of each Day Intensive and Day Rehabilitation Provider.

Below is an overview of the protocol items that would no longer be out of compliance as Providers of Day Intensive and Day Rehabilitation Services unbundle their services.

	PROTOCOL REQUIREMENTS	
7a.	Regarding Service Components for Day Treatment Intensive and Day Rehabilitation programs:	OCC if unbundled?
	1) Do Day Treatment Intensive and Day Rehabilitation programs include all the following required service components:	N/A
	A. Daily Community Meetings;*	No
	B. Process Groups;	No
	C. Skill-building Groups; and	No
	D. Adjunctive Therapies?	No
	2) Does Day Treatment Intensive Include Psychotherapy?	No

7b.	Regarding Attendance	OCC if unbundled
	1) Is there documentation of the total number of minutes/hours the beneficiary actually attended the program?	No
	2) If the beneficiary is unavoidably absent:	N/A
	A. Is the total time (number of hours and minutes) the beneficiary actually attended the program that day documented;	No
	B. Is the beneficiary present for at least 50 percent of the scheduled hours of operation for that day; AND,	No
	C. Is there a separate entry in the medical record documenting the reason for the unavoidable absence?	No

7C.	Regarding Continuous Hours of Operation:				No
	1)	Did the provider apply the following when claiming for the continuous hours of operation of Day Treatment Intensive and Day Rehabilitation services?			No
		A.	For Half Day: The beneficiary received face to face services a minimum of three (3) hours each day the program was open.		No
		B.	For Full Day: The beneficiary received face to face services in a program with services available more than four (4) hours per day.		No
7f.	Regarding the Written Program Description:				N/A
	1)	Is there a Written Program Description for *Day Treatment Intensive* and *Day Rehabilitation*?			No
		A.	Does the Written Program Description describe the specific activities of each service and reflect each of the required components of the services as described in the MHP Contract.		No
	2)	Is there a Mental Health Crisis Protocol?			No
	3)	Is there a Written Weekly Schedule?			No
		A.	Does the Written Weekly Schedule:		N/A
			a.	Identify when and where the service components will be provided and by whom: and	N/A
			b.	Specify the program staff, their qualifications, and the scope of their services?	N/A
CCR, title 9, chapter 11, section 1810.212 CCR, title 9, chapter 11, section 1810.213 CCR, title 9, chapter 11, section 1840.112(b) CCR, title 9, chapter 11, section 1840.314(d)(e)		*CCR, title 9, chapter 11, section 1840.318 CCR, title 9, chapter 11, section 1840.360 MHP Contract, Exhibit A, Attachment I DMH Letter No. 03-03*			