Section 1915(b) Waiver
Proposal For
MCO, PIHP, PAHP, PCCM Programs
And
FFS Selective Contracting Programs

SECTION B

2015 -2020
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Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	**(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)**
Access	**(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)**
Quality	**(Coverage and Authorization, Provider Selection, Quality of Care)**

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs,

including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

Part I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

MCO, PIHP, and PAHP **programs -- there must be at least one checkmark in each column.**

PCCM and FFS selective contracting **programs – there must be at least one checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."**

If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.**

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Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data							X					X
Data Analysis (non-claims)						X	X					X
Enrollee Hotlines												
Focused Studies												
Geographic mapping												
Measure any Disparities by Racial or Ethnic Groups					X		X				X	X
Network Adequacy Assurance by				X			X	X		X	X	X

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Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Plan												
Ombudsman							X		X			X
On-Site Review				X	X	X	X	X	X	X	X	X
Performance Improvement Projects					X	X	X	X	X	X	X	X
Performance Measures						X	X		X		X	X
Periodic Comparison of # of Providers							X	X			X	
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review							X			X		X
Other:												
External Quality					X	X	X	X	X	X	X	X

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Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Reviews												
Cultural Competence Plans					X	X	X	X	X		X	X
Advisory Groups					X	X	X	X	X	X	X	X
Provider Appeals										X		
County Support				X	X	X	X	X	X	X	X	X

~~Note: For waiver renewal period 8, the Monitoring Activity *Implementation Plan* has been integrated into the Monitoring Activity *Performance Measures* and the Monitoring Activity *Provider On Site Review* has been integrated into the Monitoring Activity *Onsite Reviews*~~

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Part II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- **Applicable programs (if this waiver authorizes more than one type of managed care program)**
- **Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)**
- **Detailed description of activity**
- **Frequency of use**
- **How it yields information about the area(s) being monitored**

a. ____ Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

b. _____ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

c. __X__ Consumer Self-Report data

___ CAHPS (please identify which one(s))
_X_ State-developed survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups

Strategy 1: Consumer Perception Survey

Personnel responsible: **State staff**

Detailed description of activity: **The consumer perception surveys obtain descriptive information about each consumer completing a survey. The surveys include questions about consumer satisfaction with services as well as questions about**

whether the services consumers received improved their ability to function in several domains.

During waiver period ~~8~~ 9, a convenience sampling methodology will be used similar to that used in waiver period 8 ~~7~~.

Frequency of Use: **Semi Annual**

How it yields information about the area(s) being monitored: **The consumer perception surveys are expected to yield information about clients' perceptions of access to care as well as quality and outcomes of care.**

Strategy 2: Onsite Triennial Review of MHP Beneficiary Satisfaction Policies/Processes

Personnel responsible: **MHPs develop and administer local policies and processes; State staff monitors for compliance during the triennial onsite review.**

Detailed description of activity: **All MHP's are required to have mechanism(s) or activity(ies) in place whereby the MHP can regularly gather and measure beneficiary satisfaction. Such mechanisms include but are not limited to surveys, and client focus groups. MHPs are required to have baseline statistics with goals for each year.**

During the triennial onsite reviews, state staff review the strategies used by the MHP related to beneficiary satisfaction ~~including but not limited to beneficiary satisfaction surveys or focus groups~~. ~~Such s~~Strategies may vary from county to county. State staff verify that the MHP has a strategy(ies) in place and reviews the strategy(ies) with MHP staff. Further, the MHPs provide documentation of the strategy(ies) used and examples of actions taken by the MHP in response to issues which surface during or as a result of beneficiary satisfaction strategies (i.e. reports of focus group discussions or reviews of beneficiary satisfaction survey findings). Deficiencies in this area are noted in the Plan of Corrections (POCs).

Items specific to this issue in the System Review Protocol, Quality Improvement (QI) Section I, (see attachment 11) are the following:

> **4. Does the QI work plan include goals and monitoring activities and is the MHP conducting activities in the following work plan areas?**
>
> > **4c. Monitoring beneficiary satisfaction as evidenced by:**
> > **1) A mechanism or activity is in place that regularly gathers and measures beneficiary satisfaction.**

Frequency of Use: **Reviews of MHPs occur triennially**

How it yields information about the area(s) being monitored: **The triennial review process provides the State with information on whether MHPs are complying with**

the responsibility to conduct beneficiary satisfaction activities. State staff also ask how providers are informed of the outcome of the beneficiary satisfaction activities as well as asking for examples of how the MHP uses this data to improve services and processes.

Strategy 3: Assess feasibility of collecting and reviewing results of MHP beneficiary satisfaction strategies

02/23/2015: Awaiting Updated Information

d. _X_ Data Analysis (non-claims)

- **___ Denials of referral requests**
- **___ Disenrollment requests by enrollee**
  - **___ From plan**
  - **___ From PCP within plan**
- **_X_ Grievances and appeals data**
- **___ PCP termination rates and reasons**
- **_X_ Other (please describe) Fair Hearing Data**

Strategy 1: Grievance and Appeals: Review and Analysis of MHP Annual Reports

***Personnel responsible*: State staff**

***Detailed description of strategy*: DHCS requires MHPs use a standardized reporting format to submit annual fiscal year reports that summarize the numbers of grievances, appeals and expedited appeals ~~state fair hearings~~ by ~~the general category of the complaint~~ subject areas established by DHCS (e.g., access, denial of services, change of provider, quality of care, confidentiality or other) and by disposition(e.g. referred out, resolved, still pending). By October 1 of each year, ~~T~~the reports are submitted to the County Support Unit in the Mental Health Services Division.**

During waiver period ~~8~~ 9, the grievance and appeals data will be used to ~~identify potential trends and/or~~ issues that should be addressed with the individual MHPs and/or that indicate statewide trends that ~~may~~ require technical assistance or policy clarification. Staff in the County Support U~~u~~nit will review ~~monitor the submission of~~ these reports and follow-up ~~as necessary with individual MHPs. Staff will also~~ on identified~~y potential~~ county specific and statewide trends ~~which may~~ that need to be addressed through local Quality Improvement processes (e.g., analyzing data to measure against goals, identifying opportunities for improvement, designing and implementing interventions for improving performance, measuring effectiveness of the interventions)~~more broadly~~. Additionally, staff in the County Support unit will share significant issues with Program Oversight and Compliance staff prior to and during triennial onsite reviews.

During ~~the~~ waiver period ~~8~~ 9 staff in the County Support U~~u~~nit will develop ~~and provide~~ a revised standardized reporting format for MHPs to use for their annual report. The revised format will include more clearly-defined terminology and reporting categories, to improve consistency of reporting between MHPs and yield improved quality of data to analyze. During waiver period 9, the County Support Unit will provide technical assistance and training in use of the new reporting format and develop an implementation schedule so that reporting will be consistent over each reporting period.

***Frequency of use*: Annual**

***How it yields information about the area(s) being monitored*: The grievance and appeal report from the MHPs provides ~~information~~ data on the ~~categories, process and disposition of concerns~~ ~~issues of concern~~ affecting the beneficiaries being served by each MHP, particularly in the area of access to and quality of care.**

Strategy 2: Onsite Triennial Review: MHP Grievance and Appeals Policies/Procedures

***Personnel responsible*: MHPs develop local policies and procedures; State staff review and monitor for compliance**

***Detailed description of activity*: All MHPs are required to have strategies in place to evaluate beneficiary grievances, appeals and fair hearings on an annual basis. During the triennial onsite reviews, state staff review documentation of these strategies and evidence that the annual evaluation has occurred. Staff also ask the MHP to provide 1-2 examples of grievances or appeals from receipt through resolution. Deficiencies in this area are noted in the POCs.**

Items specific to this issue in the System Review Protocol, Quality Improvement (QI) Section I, (see attachment 11) are the following:

> **4. Does the QI work plan include goals and monitoring activities and is the MHP conducting activities in the following work plan areas?**
>
> > **4c. Monitoring beneficiary satisfaction as evidenced by:**
> > **2) Annual evaluation of beneficiary grievances, appeals, and fair hearings.**

***Frequency of Use*: Reviews of MHPs occur triennially.**

How it yields information about the area(s) being monitored:
The triennial review process provides the State with information regarding whether MHPs are maintaining grievance, appeals and fair hearing data and evaluating it on an annual basis.

Strategy 3: Fair Hearing Data

Personnel responsible: **State staff and MHPs**

Detailed description of activity: **State staff provides information to MHPs regarding the status and outcome of state fair hearings for Medi-Cal beneficiaries by providing informational notices, background information, and scheduling information to the MHP. Additionally, the State maintains a database to track the status and disposition of state fair hearings.**

The MHP works directly with the beneficiary, writes the Statement of Position (SOP), and attends the State Fair hearings so that the MHP may represent its position in the hearing process.

The CDSS State Hearings Division notifies appropriate State staff when a beneficiary files a request for a state fair hearing, tracks the status of the fair hearings request, and receives the final results of fair hearings. Administrative Law Judges may consult with State staff concerning proposed decisions prior to issuing final decisions~~,~~ and/or rehearing requests.

Frequency of use: **Annual and as needed. The percentage of state fair hearings involving mental health issues is less than 1 percent of the total number of state fair hearings conducted by CDSS.**

How it yields information about the area(s) being monitored:
The review of fair hearing data provides State staff with the ability to provide technical assistance to MHPs on specific fair hearing issues.

e.___ Enrollee Hotlines operated by State

f. ___ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

g. __ Geographic mapping of provider network

h. X Measurement of any disparities by racial or ethnic groups

Strategy 1: Review/Analysis of data

Personnel responsible: **State staff**

Detailed description of activity: **Data from a variety of sources is reviewed and analyzed for indicators of potential disparities in beneficiaries' access to SMHS in the context of race/ethnicity it's ~~. Data is also~~ analyzed ~~in the context of race/ethnicity~~ by gender, age, diagnosis and other factors when such information is**

available. Data from the Short Doyle/Medi-Cal System (SD/MC) and the Client and Service Information System (CSI) are processed through programming code in SAS to create counts, sums, and statistics in meaningful categories that can be compared to other data sources. Paid claims and CSI data contain protected health information and personal information of beneficiaries, so the data must be de-identified, primarily by aggregation, before shared with outside parties

Sources include:

- **Statewide Cultural/Ethnic Population Data obtained from California's Department of Finance This information is free and available to the public**
- **Paid Claims Data from SD/MC broken out by MHP, cost of service, demographic information, and dates of services.**
- **Client and Service Information System (CSI) contains geographic data elements (county, city, MHP), primary and preferred language, ethnicity, race, and gender.**

Frequency of use: **As needed.**

***How it yields information about the area(s) being monitored*: Review and analysis of this data ~~as described above~~ assists the State to determine potential disparities. The data is archived and updated on a periodic basis and allows the State to choose any number of time periods in the past to analyze potential disparities. One way this data yields information is by comparing the racial or ethnic proportions of the entire population to the proportions of the same racial or ethnic groups that are receiving SMHS in the claims and CSI data.**

Strategy 2: Onsite Triennial Review: MHP's Policies/Procedures Regarding Access to Culturally/Linguistically Appropriate Services

Personnel responsible: **State staff and MHPs.**

Detailed description of activity: **MHPs are required in their CCP to address and update strategies and efforts for reducing disparities in access to SMHS and quality and outcome of these services in the context of racial, ethnic, cultural, and linguistic characteristics. Further, all MHPs are required to have mechanism(s) or activity(ies) in place whereby the MHP can assess the availability of appropriate cultural/linguistic services within the service delivery capacity of the MHP. Such mechanism(s) include but are not limited to:**

- **A list of non-English language speaking providers in the beneficiary's service areas by category;**
- **Culture-specific providers and services in the range of programs available;**
- **Beneficiary booklet and provider list in the MHPs identified threshold languages;**

- **Outreach to under-served target populations informing them of the availability of cultural/linguistic services and programs;**
- **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 that will provide information to beneficiaries about access, services and the use of beneficiary problem resolution/fair hearings;**
- **Interpreter services;**

During the triennial onsite reviews, state staff reviews information provided by the MHP to ensure that the above mechanisms are in place. Deficiencies in this area are noted in the POCs.

Examples of items specific to this issue in the System Review Protocol, Access Section A, (see attachment 11) are:

> **11. Is there evidence that Limited English Proficient (LEP) individuals are informed of the following in a language they understand: a) LEP individuals have a right to free language assistance services; b) LEP individuals are informed how to access free language assistance services; and c) Is there documented evidence to show that the MHP offered interpreter services?**
>
> **13. Has the MHP developed a process to provide culturally competent services as evidenced by: a) A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing SMHS employed by or contracting with the MHP, to provider interpreter or other support services to beneficiaries; b) Implementation of training programs to improve the cultural competence skills of staff and contract providers; and c) A process that ensures the interpreters are trained and monitored for language competence.**

Examples of items specific to this issue in the System Review Protocol, Target Populations Section E (see attachment 11) are

> **1a. To the extent resources are available, are services encouraged in every geographic area and are the services to the target populations planned and delivered so as to ensure access by members of the target populations, including all ethnic groups in the state?**
>
> **1b. To the extent resources are available, is the county organized to provide an array of treatment options in every geographic area to the target population categories as described in W&I section 5600.3, including all ethnic groups?**

***Frequency of Use*: Reviews of MHPs occur triennially.**

***How it yields information about the area(s) being monitored*: The triennial review process provides the State with information as to whether MHPs are complying with their responsibility to provide mechanism(s) about culturally and linguistically appropriate services as a core component of access and quality of care.**

i. X Network adequacy assurance submitted by plan [Required **for CO/PIHP/PAHP]**

Strategy 1: MHP Contract

***Personnel responsible*: State staff and MHPs**

***Detailed description of activity:* The MHP contract (Exhibit A1, Items 2C and D) requires MHPs to offer an appropriate range of specialty mental health services that is adequate for the anticipated number of beneficiaries for the service area and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area. In addition, MHPs are required to report to the Department whenever there is a change in their operation that would cause a decrease of 25 percent or more in services or providers available to beneficiaries ~~or a reduction of an average of 25 percent or more in outpatient provider rates~~. MHPs must also provide details regarding the change and plans to maintain adequate services and providers available to beneficiaries.**

***Frequency of use:* When there is a significant change in an MHP's network.**

***How it yields information about the area(s) being monitored:* Assurance from the MHPs that their networks are adequate to meet the needs of the beneficiaries being served provides the State with more current information on the MHPs' networks than might be obtained through on-site reviews or other monitoring activities.**

Strategy 2: Onsite Triennial Review: MHP's Policies/Procedures Regarding Numbers and Types of Providers

***Personnel responsible*: MHPs develop local policies/procedures; State staff review and monitor for compliance**

***Detailed description of activity* Each MHP is required to have a Quality Improvement Work Plan that includes its plan to monitor its service delivery capacity as evidenced by a description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system. Further, the plan must include goals established for the number, type, and geographic distribution of mental health services. During the triennial onsite reviews, state staff review the QI Work Plan and Work Plan Evaluation to verify that goals have been established regarding the number, type and geographic distribution of mental health services within the MHP's delivery system. Staff also review the MHP provider list. Often the MHP will provide a map displaying geographic distribute of services. Deficiencies in this area are noted in the POCs.**

Items specific to this issue in the System Review Protocol, Quality Improvement (QI) section (see attachment 11) are the following:

> **4. Does the QI work plan include goals and monitoring activities and is the MHP conducting activities to meet the following work plan areas?**

4a Monitoring the service delivery capacity of the MHP as evidenced by:

1) **A description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system.**
2) **Goals are set for the number, type, and geographic distribution of mental health services.**

Frequency of Use: **Reviews of MHPs occur triennially.**

How it yields information about the area(s) being monitored: **The triennial review process provides the State with information as to whether MHPs are complying with their responsibility to monitor their service delivery capacity.**

j. X Ombudsman

Personnel responsible: **State staff and MHPs**

Detailed description of activity: **The purpose of the Ombudsman Office is to be a bridge between the mental health system and ~~eligible beneficiaries receiving Medi-Cal specialty~~ individuals attempting to access those services mental health services, by providing information and assistance to help people navigate the system.**
In addition to assistance available through an MHP, it is important for the State to assist beneficiaries for three reasons:

- **If the beneficiary believes there is the potential for conflict with their MHPs, he/she may feel uncomfortable or fearful about approaching the MHP directly.**
- **The more assistance and resources are accessible to the beneficiary, the more likely it is that they will seek such assistance.**
- **Involvement in beneficiary protections is an important part of state oversight of the waiver program.**

The Ombudsman Office operates a toll-free telephone number. The phone line has staff available Monday through Friday during normal business hours from 8 a.m. to 5 p.m. During periods when staff persons are unavailable, callers can access a confidential voicemail 24 hours a day. The voicemail directs callers to 911 if there is an emergency in both English and Spanish and provides instruction in how to contact their local county mental health departments. Staff follow-up in response to voice mail each day within a prudent and reasonable timeframe ~~based on the nature and complexity of the calls~~. The Ombudsman office also has a dedicated email address to provide an opportunity for written communication.

The office provides information and presents options to beneficiaries to access SMHS. B~~b~~eneficiaries have an opportunity to voice their concerns, brainstorm what steps they might take to resolve issues in regards to access and gain knowledge of how they might advocate for themselves. The Ombudsman office also assists callers by interfacing with the local Patient's Rights advocate or the ~~assigned~~ MHP

problem resolution contact to resolve issues s about access, quality of care, grievance, appeals, and state fair hearings or other issues of concern to the callers.

With most complex cases, the Ombudsman Office will link the beneficiary with an MHP problem resolution contact ~~by scheduling a telephone conference~~ to identify a resolution(s) satisfactory to the beneficiary. The office ~~also serves as an avenue for all Medi-Cal dually-insured beneficiaries, and persons without insurance in providing~~ provides information and assistance on other issues of concern; for example, assisting beneficiaries to connect with appropriate local resources and/or agencies for resolution.

In cases when the issue may be one of contract compliance by a MHP, the Ombudsman Office will also make a referral to state staff assigned to work with individual MHPs. State staff from other units may work with the Ombudsman Office prior to an audit or review of an MHP to focus attention on potential issues at a particular MHP.

Frequency of use: **Beneficiaries are able to contact the office 24 hours a day 7 days a week by telephone, voicemail, and email. Staff is available between normal business hours of 8 a.m. to 5 p.m. (Monday – Friday) excluding holidays.**

How it yields information about the area(s) being monitored: **The Ombudsman Office utilizes a database for tracking purposes. This database is used to record and produce reports on the numbers of calls, type of calls, language of the caller, caller's county, and subject area of calls. Although the number and type of calls are not used as direct indicators of system performance, this information can be used to identify potential problems ~~providing an opportunity for the Ombudsman office to research and prepare resources and options for beneficiaries~~.**
The Ombudsman office works to keep current with changes in governmental policies and procedures that may directly affect beneficiaries served at the local level. This is done by following governmental releases and/or media releases and participating on committees and in workgroups.

k. **X** **On-site review**

There are four components/strategies to the State's on site review activities:

1) Triennial Systems Reviews
2) Triennial Chart Reviews- Non-Hospital Services (Outpatient) Adult and Children/Youth
3) SD/MC Hospital Inpatient Reviews
4) Provider Certification On-Site Reviews

Results for each component are described below

~~1.~~ Strategy 1: Triennial System Reviews of the MHP

Detailed description of activity: **The triennial on-site system reviews of the MHPs are conducted to determine the MHP's compliance with state and federal regulations,**

provisions of the approved 1915(b) waiver and DHCS/MHP contractual requirements. The compliance review protocol for FY ~~2012-2013~~ 2014-2015 includes the following system review sections: 1) Access; 2) Authorization; 3) Beneficiary Protection; 4) Funding, Reporting and Contracting Requirements; 5) Target Populations; 6) Interface with Physical Health Care; 6)Provider Relations; 7) Program Integrity; and 8) Quality Improvement (see attachments 11 & 12). The compliance protocol includes items regarding the MHP's Cultural Competency Plans, Quality Improvement Plans, Compliance Plans, the MHP's policies and procedures and the MHP's application of the policies and procedures in practice.

The MHP's receive a final report summarizing the findings of the compliance review and are required to submit a Plan of Correction (POC) for each of the protocol items found out of compliance within 60 days of receipt of the final report.

The POC must include the MHP's proposed corrective action and documentation of the implementation of the corrective action. DHCS County Support Unit receives a copy of the final report and the MHP's POC and provides technical assistance to the MHPs as needed.

The MHP may appeal the review findings in writing within 15 working days of the receipt of the final report to the DHCS appeals officer.

The protocol is reviewed annually and revised as necessary. The Compliance Advisory Committee (CAC), in accordance with the Welfare and Institutions Code, Section 5614, reviews the compliance protocol and provides consultation and recommendations to the Department. The CAC is comprised of representative stakeholders including consumers, family members advocates, mental health departments, community based providers and mental health boards.

***Personnel responsible*: State staff**

***Frequency of use:* Each MHP is reviewed triennially**

***How it yields information about the area(s) being monitored:* The on-site system reviews yield information about each MHP's compliance with regulatory and contractual requirements of the waiver, including access, authorization, beneficiary protection, funding, reporting and contracting requirements, target populations and array of services, interface with physical health care, provider relations, program integrity and quality improvement.**

~~2~~. Strategy 2: Triennial Chart Reviews- Non-Hospital Services (Outpatient) Adult and Children/Youth

-***Detailed description of activity:* The triennial non-hospital outpatient chart reviews are conducted to monitor and ensure compliance with state and federal regulations and statutes and DHCS/MHP contractual requirements. The review team is composed of licensed mental health clinicians and includes both state staff and**

contractors. The State provides oversight to ensure that the Medi-Cal claims submitted by the MHP's for specialty mental health services (SMHS) met medical necessity criteria for reimbursement and that the documentation in the medical records provided contain the required evidence of medical necessity. The current protocol being used can be found in the ANNUAL REVIEW PROTOCOL FOR CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES (see attachment 11).

The chart sample for the reviews is provided by DHCS staff using established sampling methodology. The sample is drawn from the most recent 90 day period for which paid claims data is available. The chart sample consists of 10 beneficiaries or 20 beneficiaries depending on the size of the county population and consists of one half adult beneficiaries and one half children/youth.

.The team reviews the charts to determine whether the documentation supports the medical necessity criteria for non-hospital (outpatient) services. Chart documentation reviewed by the team includes the following:

- **Medical Necessity**
- **Assessment**
- **Client Plan**
- **Progress Notes**
- **Medication consents**
- **Medi-Cal and other insurance coverage**
- **Legal status, conservatorship and 5150 documentation and other legal documents**
- **Cultural and linguistic access**
- **Other Chart Documentation**

Disallowances are determined in accordance with MHSUDs Information Notice No. ~~12-05~~ 14-27 "Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services for Fiscal Year ~~2012-2013~~ 2014-2015" Enclosure 4 Reasons for Recoupment (see attachment 13) Disallowances are only taken on claims for services documented in the review sample. Currently, t~~T~~here is no extrapolation of the findings, however the state is in the process of developing plans for the application of corrective measures which could include extrapolation.

The MHPs receive a final report with a summary of the findings of the non-hospital outpatient chart review and are required to submit a Plan of Correction (POC) for each of the non-hospital protocol items found out of compliance within 60 days of receipt of the final report. The POC must describe the MHP's corrective action and provide documentation of the implementation of the corrective action. DHCS County Support Unit receives a copy of the final report and the MHP's POC and provides technical assistance to the MHPs as needed. The MHP may appeal the review findings within 15 working days after receipt of the final report to the DHCS appeals officer.

Personnel responsible: **State staff**

Frequency of occurrence of reviews: **The non hospital (outpatient) chart reviews are conducted on a triennial basis. Eighteen to twenty MHPs are reviewed each fiscal year and all 58 MHPs are reviewed during the three year cycle.**
How it yields information about the areas being monitored: **The non-hospital (outpatient) chart reviews provide information on the degree of compliance to which SMHS provided by a MHP and their contracted providers meet medical necessity criteria for non-hospital (outpatient) services. Chart reviews also assist the State in determining if the MHP and their contracted providers are billing and claiming appropriately, and following the MHP's own chart documentation standards. This information enables the State to recoup FFP funds for those non-hospital (outpatient) SMHS which do not meet appropriate regulatory requirements.**

~~3.~~ Strategy 3: SD/MC Hospital Inpatient Reviews

Personnel responsible: **State staff**

Detailed description of activity: **A review team consisting of state staff and licensed mental health practitioners under contract to the State including, at a minimum, a physician and one or more licensed mental health professionals, conducts triennial reviews of SD/MC acute psychiatric inpatient hospitals. The principal focus of these reviews is to determine the following: (1) Whether the hospital's Utilization Review Plan meets requirements outlined in Title 42 of the Code of Federal Regulations Section 456.201-456.245: ; (2) Whether Medical Care Evaluation Studies have been performed as required by Title 42 of the Code of Federal Regulations Section 456.242-243 and whether they have been conducted in a methodologically acceptable fashion; (3) Whether the Plan of Care for each beneficiary meets the standards set forth in Title 42 of the Code of Federal Regulations; (4) Whether documentation for reimbursement of acute hospital days meets the requirements set forth in Section 1820.205 of Title 9 of the California Code of Regulations; (5) Whether documentation for reimbursement of administrative days meets the requirements described in Section 1820.220 of Title 9 of the California Code of Regulations; (6) Whether the hospital's utilization review function is effectively identifying those days for which documentation does not meet medical necessity criteria for admission or continued stay services, or regulatory requirements for administrative day services; and (7) Whether the quality of treatment provided to all beneficiaries meets acceptable community standards of care. The current protocol for these reviews, Sections K and L of the Compliance Protocol for Consolidated SMHS, is included in MHSD Information Notice No. 12-05, which can be found on the DHCS website at http://www.dhcs.ca.gov/formsandpubs/MHCCY/Enclosure1-FINAL_PROTOCOL_FY2012-13.pdf (see attachment 11)**

A sample of 60 admissions is drawn randomly from the universe of all hospital admissions during the most recent 90-day period for which claims appear to be

complete. If there are fewer than 60 admissions in the most recent 90-day period for which claims appear to be complete, the audit will take as its subject all of the admissions for which claims were paid during that 90 day period.

The review team reviews the charts to determine whether the documentation supports the medical necessity criteria for acute psychiatric inpatient hospital services, as well as the requirements for administrative day services when applicable. Chart documentation reviewed by the team includes the following:

- **Physicians' admitting, treatment and discharge orders**
- **Physicians' admission summary**
- **History and physical examination**
- **Physicians', nurses' and social workers' progress notes**
- **Physicians' discharge summary**

In addition, the team reviews the medical records to determine the following:

- **Whether there is a written plan of care which includes the following elements:**
  - **Diagnoses, symptoms, behaviors, complaints or complications which indicate the need for admission to an acute psychiatric inpatient hospital**
  - **A description of the functional level of the beneficiary**
  - **Treatment objectives which are behaviorally specific and/or behaviorally quantifiable**
  - **A description of proposed interventions including duration**
  - **Orders for:**
    - **Medications**
    - **Treatments**
    - **Restorative and rehabilitative services**
    - **Activities**
    - **Therapies**
    - **Social Services**
    - **Diet**
    - **Special procedures recommended for the health and safety of the beneficiary**
  - **Plans for continuing care**
  - **Plans for discharge**
  - **Documentation of the beneficiary's degree of participation in and agreement with the plan**
  - **Documentation of the physician's establishment of the plan**

- **Whether documentation reflects staff efforts to screen, refer and coordinate with other necessary services, including, but not limited to:**
  - **Substance abuse treatment**
  - **Educational services**
  - **Health services**
  - **Housing services**
  - **Vocational rehabilitation services**

- **Regional Center services**

Frequency of occurrence of reviews: **Every third year. If significantly elevated rates of disallowance or quality of care concerns are detected, reviews may be scheduled more frequently, or may focus on particular areas of concern.**

How it yields information about the area(s) being monitored: **The SD/MC hospital inpatient reviews provide information on the degree to which beneficiaries' medical records meet medical necessity criteria for admission and continued stay services and, where appropriate, requirements for administrative day services. This information enables the State to recoup FFP funds for those hospital days which do not meet appropriate regulatory requirements.**

~~4.~~ Strategy 4: Provider Certification On-Site Reviews

Personnel responsible:–**MHPs and State staff**

Detailed description of activity: **Per DMH Letter 10-04, (see attachment 15) the certification and re-certification of county owned/or operated organizational providers is the joint responsibility of the State and MHPs. The certification and re-certification of organizational providers contracting with the MHPs is the responsibility of the MHPs with the State approving and processing the required documentation.**

The Department is responsible for an onsite certification review of County owned and operated sites:

- **~~that request~~ For new Medi-Cal certification ~~or re-certification when the following services are provided or activated or~~**
- **W~~w~~hen there is a change of address/location**
- **When there is an addition of medication mode of services to existing certifications and medication is stored on site**
- **When recertifying the following services**
  - **Crisis Stabilization Units,**
  - **Juvenile detention facilities,**
  - **Day treatment intensive (full and half day programs),**
  - **Day treatment rehabilitative providers (full and half day programs),**
- ~~**When there is an addition of medication mode of services to existing certifications**~~

The State conducts Medi-Cal provider site certification and recertifications in accordance with Title 9 and DHCS/MHP contractual requirement. The "Provider Site Re/Certification Protocol" is the standardized review tool utilized for the provider site certification and recertification process (see attachment 15).

Frequency of occurrence of reviews: **Certification and recertification of county owned and operated provider sites are conducted as required.**

How it yields information about the area(s) being monitored: **The certification and recertification of county owned and operated provider sites ensure that the specialty mental health services are being certified and the facility itself meets all regulatory and contractual requirements**

l.. X Performance Improvement Projects [Required for MCO/PIHP]

X Clinical
X Non-clinical

Personnel responsible: **MHPs**

Detailed description of activity: **Since 1997, MHPs have been required by Title 9, CCR, Section 1810.440 and CFR Title 42 438.240(b)(1) to have a QI Program that meets specific minimum standards. The MHP contract, Exhibit A Attachment 1, Item 23 specifies the standards for the MHP's quality management and quality improvement programs which includes conducting at least two Performance Improvement Projects (PIPs), one clinical and one non-clinical that meet the validation standards applied by the EQRO contractor. The validation standards are:**

- **Monitoring the service delivery capacity of the MHP**
- **Monitoring the accessibility of services**
- **Monitoring beneficiary satisfaction**
- **Monitoring the MHP's service delivery system and meaningful clinical issues affecting beneficiaries, including safety and effectiveness of medication practices.**
- **Monitoring continuity and coordination of care with physical health care providers and other human services agencies**

During the ~~eighth~~ ninth waiver period the EQRO will be collecting information regarding the two required PIPs and reporting findings in their quarterly and annual reports. Data gathered from the PIPs will be available during the ~~eighth~~ ninth waiver period to assist MHPs to continue to make program enhancements to improve the coordination, quality, effectiveness, and/or efficiency of service delivery to children who are receiving EPSDT services. Currently, there are ongoing discussions between DHCS and the EQRO regarding the possible development of a statewide PIP related to timeliness of and access to services, although timeliness and access may instead be validated through Performance Measures.

Frequency of use: **Ongoing; Each MHP is required to have an annual planning process for active clinical and non- clinical PIPs.**

How it yields information about the area(s) being monitored: **PIPs and other quality improvement activities, depending on the specific issues selected for study, can provide the MHPs with information on access, quality of care, continuity/coordination of care, the grievance system, beneficiary informing, and**

provider selection and capacity. Two of the PIPs, one clinical and one non-clinical are reviewed by the EQRO (for more information regarding the EQRO see section s1 page ~~103~~) (insert correct page number in final draft) and a report is completed after each review. These reports provide concrete information on the validity of MHP PIPs.

m. X **Performance measures** [Required for MCO/PIHP]

- X **Process**
- X **Health status/outcomes**
- X **Access/availability of care**
- X **Use of services/utilization**
- X **Health plan stability/financial/cost of care**
- ___ **Health plan/provider characteristics**
- X **Beneficiary characteristics**

Strategy 1: Measurements of indicators of mental health system performance on an ongoing and periodic basis.

Personnel responsible: **State staff**

Detailed description of Activity:

- **Paid Claims Data**
  - **Mean Monthly Specialty Mental Health (MH) Client Counts by Fiscal Year Quarter**
  - **Mean Monthly Population Served by Age and Race**
  - **Total Cost of Services/Medi-Cal Expenditures**
  - **Costs of Services/Medi-Cal Expenditures by Race**
  - **Types of Services by cost**
  - **Penetration Rate**

- **Consumer Perception Survey**

Information on the consumer perception survey can be found in section c pages ~~81-83~~) (insert correct page number in final draft) and section 1 on page ~~111~~) (insert correct page number in final draft).

  - **Perception of Access to Services**
  - **Perception of Quality and Appropriateness of Services**
  - **Perception of Outcomes**
  - **Perception of Participation in Treatment Planning/Family Member Participation in Treatment Planning**
  - **General Satisfaction with Services**
  - **Perception of Changes in Functioning**
  - **Perception of Changes in Social Connectedness**
  - **Perception of Cultural Sensitivity of Staff**

- **Performance Outcomes System (POS) for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Mental Health Services**

The POS approaches evaluation of California's specialty mental health services for children and youth from a broad-based perspective. POS measures the quality and accessibility of services for children and youth and provides information that improves practice at the individual, program, and system levels. POS will ensure the use of evidence-based mental health practices appropriate to client needs that demonstrate effectiveness and positive client outcomes. The outcomes are measured on four levels: Individual (youth/family), Provider, System, and Community (public) levels. POS will measure the outcomes of seven domains:

- **Access**
- **Engagement**
- **Service Appropriateness to Need**
- **Service Effectiveness**
- **Linkages**
- **Cost**
- **Satisfaction**

DHCS staff will use data captured in legacy systems that were developed and maintained by the former Department of Mental Health (DMH) and the DHCS's data warehouse to generate the Performance Outcomes System reports. Data submitted to existing DHCS legacy systems come from the counties. The following systems are:

- **Client and Services Information System**
- **Data Collection and Reporting System**
- **Management Information System/Decision Support System**
- **Short Doyle/Medi-Cal Claiming System**
- **Web-Based Data Collection Reporting System - Consumer Perception**

Frequency of use: **Information is gathered and reports created on an as needed basis.**

How it yields information about the area(s) being monitored: **Results provide information about access, cost and the overall functioning of the mental health system**.

Strategy 2: Implementation Plans

Personnel responsible: **MHPs and State staff**

Detailed description of activity: **The State requires MHP applicants to submit ~~i~~Implementation ~~p~~Plans that provide assurance that the entity has the capacity to be a successful MHP. Implementation ~~p~~Plan requirements are described in Title 9,**

CCR, Sections 1810.305 and 1810.310 and in DMH Information Notice No. 97-06 which can be found at http://www.dmh.ca.gov/DMHdocs/docs/notices97/97-06not.pdf (see attachment 14) The Implementation Plan ~~implementation plan~~ process assists in monitoring the waiver program by ensuring that each MHP has the basic systems in place prior to the enrollment of beneficiaries with the MHP.

In accordance with CCR Title 9 section 1810.310(c) ~~The implementation plan process also requires~~ MHPs are also required to submit proposed changes to their I~~i~~mplementation P~~p~~lan to the State for review and approval ~~(see CCR Title 9 section 1810.310 (c))~~. Proposed changes in the policies, processes or procedures that would modify the MHP's current Implementation Plan must be submitted prior to implementing the proposed changes.

Frequency of use: **~~Once per MHP for the initial plan with ongoing updates~~ MHPs will submit their most recent version of their Implementation Plan this current waiver cycle, to ensure that the State has reviewed and approved the current Implementation Plan for each MHP.**

MHPs must submit an updated Implementation Plan when changes are proposed that would modify the MHPs Implementation Plan .

How it yields information about the area(s) being monitored: **The Implementation Plan approval process for new MHPs provides basic information on an applicant's operational plans for serving as an MHP. The Implementation Plan for operational MHPs provides the State with a basic description of the MHP's systems for providing services to Medi-Cal beneficiaries. The approval process for changes to the operational MHP's Implementation Plans ensures that the ~~State~~ descriptions of the MHP's processes, policies and procedures are current ~~and~~ which provides immediate information to state staff regarding changes made or planned by the MHP.**

Strategy 3: Onsite Triennial Review: MHP's Quality Improvement (QI) Program

Personnel responsible: **MHPs and State staff**

Detailed description of activity: **Each MHP is required (in accordance with the MHP/DHCS contract (Exhibit A, Attachment 1, Section 23), CCR, title 9, Section 1810.440 and CFR Title 42 Section 438.204, 240 and 358) to have a QI program, the purpose of which is to review the quality of specialty mental health services provided to beneficiaries by the MHP. The QI Program must have active participation by the MHP's practitioners and providers, as well as beneficiaries and family members.**

Activities specific to monitoring access, continuity of care and quality include but are not limited to:

- **Collecting and analyzing data to measure the goals, or prioritized areas of improvement that have been identified;**
- **Identifying opportunities for improvement and deciding which opportunities to pursue;**
- **Identifying relevant internal or external committees to ensure appropriate exchange of information with the QI Committee;**
- **Obtaining input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services;**
- **Designing and implementing interventions to improve performance;**
- **Measuring effectiveness of the interventions;**
- **Incorporating successful interventions into the MHP's operations as appropriate; and**
- **Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by CCR, title 9, section 1810.440(a)(5).**

During the triennial System Reviews, state staff review the QI work plan for evidence of QI activities that the MHP has engaged in including recommending policy changes, evaluation of QI activities, instituting needed actions, and ensuring follow-up of QI processes and previously identified issues. The MHP is also asked to show how they evaluate the effectiveness of the QI program and how QI activities have contributed to improvement in clinical care and beneficiary services. Staff verify that the MHP has identified goals and evidence of how they are monitoring the service delivery capacity of the MHP, the accessibility of services, beneficiary satisfaction, and the annual review of grievances/appeals/fair hearings and beneficiary requests to change the person providing services. The MHP is also asked how they monitor their delivery system in terms of relevant clinical issues, safety and effectiveness of medication practices, and what interventions are implemented when potential poor care issues are identified.

Specific protocol items related to this issue can be found in the System Review Protocol Section I, Quality Improvement (QI) section (see attachment 11).

***Frequency of use*: The MHP's are required to review the QI Work Plan and revise as appropriate on an annual basis. During the triennial System Review state staff review both the QI Work Plan itself and evidence that activities identified in the Work Plan were implemented.**

***How it yields information about the area(s) being monitored*: The review of the QI Work Plan itself and of the monitoring activities incorporated in the Work Plan provides information to both state and local staff in the following areas:**

- **Service delivery capacity as evidenced by a description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system and set goals for the number, type, and geographic distribution of mental health services;**
- **Timeliness of routine mental health appointments;**

- **Timeliness of services for urgent conditions;**
- **Access to after-hours care;**
- **Responsiveness of the 24/7 toll-free number;**
- **Beneficiary satisfaction;**
- **Beneficiary grievances, appeals, and fair hearings;**
- **Requests for changing persons providing services;**
- **Relevant clinical issues, including the safety and effectiveness of medication practices;**
- **Interventions when occurrences of potential poor care are identified;**
- **Identification and evaluation of barriers to improvement related to clinical practice and/or administrative aspects of the delivery system by providers, beneficiaries, and family members; and**
- **Provider appeals**

Strategy 4: Development of Performance Outcome System (POS)

Personnel responsible: **State staff and Stakeholders**

Detailed description of activity: **Welfare and Institutions [W&I] Code, Section 14707.5 (added by Senate Bill [SB] 1009, Statutes of 2012, and amended by Assembly Bill [AB] 82, Statutes of 2013) requires DHCS, in collaboration with the California Health and Human Services Agency and in consultation with the Mental Health Services Oversight and Accountability Commission (MHSOAC), to create a plan for a Performance Outcomes System for Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) mental health services. The Performance Outcomes System implementation will establish a process for bringing together information from multiple sources in order to better understand the results of Medi-Cal SMHS provided to children and youth. The statute requires that a performance outcomes system for Medi-Cal specialty mental health services for children and youth be developed to improve outcomes at the individual, program, system, and community levels and to inform fiscal decision-making related to the purchase of services.**

There are seven domains that will link together the elements of the Performance Outcomes System. These reflect the domains established at the national level by SAMHSA. DHCS, working with stakeholders and partners, has established a framework for outcomes measurement by identifying these domains as key areas to assess:

- **Access;**
- **Engagement;**
- **Service Appropriateness to Need;**
- **Service Effectiveness**
- **Linkages;**
- **Cost;**
- **Satisfaction**

Performance Outcome System Process and Goals

- **Continued Stakeholder Involvement (Stakeholder Advisory Committee, Subject Matter Experts Work Group, Measures Task Force meetings)**
- **Establish Performance Outcomes System Methodology**
- **Initial Performance Outcomes Reporting: Using Existing DHCS Databases**
- **Continuum of Care: Screenings and Referrals**
- **Comprehensive Performance Outcomes Reporting: Expanded Data Collection**
- **Continuous Quality Improvement (QI) Using Performance Outcomes Reports**

While the focus of the Performance Outcomes System is children and youth receiving Medi-Cal specialty mental health services, DHCS is taking a more comprehensive view and developing the system to look at outcomes for all SMHS.

Quality Improvement

As part of a comprehensive system of reporting, analysis, and improvement, DHCS will develop a quality improvement process to strengthen the structure and processes of mental health delivery systems and share successful and cost-effective practices between MHPs. Strategies will specifically focus on partnering, educating, and training MHPs and their providers on removing barriers to access mental health services. Further, training efforts will include providing standards of care using diagnostic assessments and evidence-based treatment, such as trauma-informed care that allows for reducing disparities among children and youth. DHCS acknowledges that many MHPs already utilize performance outcomes information to improve the quality of services to children and youth, and that it would be beneficial to partner with specific MHPs to assist with sharing of successful practices.

- **DHCS conducting interviews with other States, MHPs, and Provider Organizations**
  - **Discussed lessons learned during the development of their performance and outcomes systems**
- **DHCS staff are in the process of creating a proposed quality improvement committee structure (including a statewide committee and sub-committees) aimed at improving mental health services for children and youth in California This will provide a forum to exchange information regarding Performance Outcomes System implementation and identify any barriers that may impede implementation efforts, and will expand upon current statewide and regional QI forums. The committee structure will identify best practices for developing QI processes, conduct state-level analysis of Performance Outcomes System data, improve service delivery models, and provide training. The over-arching objective is to improve mental health services and outcomes for children and youth.**

- **Counties will likely have differing levels of complexity associated with their data quality issues, which will require differing lengths of time to address. It is anticipated that small counties will have significantly different data quality needs. DHCS will assist counties in assessing and improving processes for data collection, data management, business processes and staff and planning for the expanded data collection efforts.**
- **Once the initial reports are developed, quality improvement activities will expand to providing the feedback loop between counties and DHCS on data and sharing information from successful programs.**

Frequency of use: **Information is gathered and reports created on a frequency schedule to be determined by DHCS, based on stakeholder input and data systems capabilities.**

How it yields information about the area(s) being monitored: **DHCS and the Stakeholder Advisory Committee and subgroups will develop standardized report templates. The frequency of the reports deliverable will be dependent on the comprehensive review of the data systems, frequency desired by stakeholders, and ability to produce data to be analyzed in the reports. The specific data system areas that will be reviewed are data collection and reporting times, quality, and uniformity. The goal of the reports are to show the impact of mental health services and programs on individuals, providers, systems and the community, and to identify areas that need improvement. DHCS staff will continue the collaborative process by providing technical assistance and training to county staff on how to interpret and utilize the data to support services and programs.**

n. Periodic comparison of number and types of Medicaid providers before and after waiver.

2/23/2015: Awaiting Updated Information

o.. ___ Profile utilization by provider caseload (looking for outliers)

p. ___Provider Self-report data

___ Survey of providers
___ Focus groups

q.. ___ Test 24 hours/7 days a week PCP availability

r.. _X_ Utilization review (e.g. ER, non-authorized specialist requests)

~~Strategy:~~ MHP Utilization Management Program (UMP): Payment Authorization System

Personnel responsible: **MHPs/State staff**

Detailed description of activity: **MHPs are required ~~to~~ to have a UMP which addresses ~~to~~ consistent application of medical necessity in their payment authorization systems. The UM Pin each MHP assists in monitoring the waiver program by ensuring that each MHP has systems in place to ensure beneficiaries have appropriate access to specialty mental health services as required by Title 9, CCR, Section 1810.440 and the MHP contract, Exhibit A, Attachment 1, Item 24.**

MHPs are required to establish MHP payment authorization systems consistent with Title 9, CCR, Section 1810.350, 1820.215, 1820.220, 1820.225 and 1820.230 for psychiatric inpatient hospital services and Section 1830.215 for all other services.

MHPs may determine whether or not to require prior authorization of services, with a few exceptions. MHPs may not require prior authorization of emergency services. However, as specified in the MHP contract Exhibit A, Attachment 1 item 8, MHPs must require prior authorization of day treatment intensive services, and day rehabilitation if those services will be provided more than five days a week. Additionally, MHPs must complete TARs for FFS/MC hospitals to allow payment by the Medi-Cal fiscal intermediary. In most cases the TARs are completed after the beneficiary is discharged.

During the triennial onsite reviews, state staff review the MHP's Utilization Management Program to assess whether MHPs provide beneficiaries access to specialty mental health services in the context of their established authorization criteria.

Frequency of use: **Annual evaluation by the MHP; Triennial review by state staff**

How it yields information about the area(s) being monitored: **The triennial review process provides the State with information as to whether the MHP UMP addresses access to services in the context of the MHP's authorization systems.**

s. X Other: (please describe)

1. **External Quality Reviews (EQRs)**

Personnel responsible: **State staff and EQRO contractor**

Detailed description of activity:
EQR activities are conducted with a focus on three overarching principles which have been agreed upon by the EQRO, the State and the MHPs as being core to the EQRO and which are embedded in each review:

- **Cultural competence**
- **Consumer/family empowerment and involvement**
- **Wellness and recovery**

The three primary activities in which the EQRO contractor engages during reviews of MHPs in order to meet the requirements for EQR are:

- **PIP: Reviewing the validity of two MHP PIPs.**
- **Information Systems Capability Assessment (ISCA): Utilizing a California-specific ISCA protocol to review the integrity of the MHP's' information systems and the completeness and accuracy of the data produced by those systems.**
- **Technical Assistance and Training: Providing technical assistance and training as part of the site review and as well as post review.**

The review of each MHP is customized each year according to the findings of the previous year's reviews on statewide issues as well as the issues and recommendations made by the EQRO to that MHP in the context of their previous review. It includes an evaluative process of the overall service delivery system as it relates to business practices and strategic planning and development.

Representatives from the following MHP units are requested to participate in the review:

- **Executive leadership**
- **Information systems**
- **Finance, Data, and Operations**
- **Quality improvement**
- **Key direct clinical service staff and clinical supervisors**
- **Organizational contract providers**

The list of planned participants is discussed in detail with the lead reviewer prior to the site review in order to ensure that the appropriate staff members are included in each component of the review. The role of contract providers throughout the review is determined by consultative discussion between the lead reviewer and the MHP contact for the review.

Prior to the actual review, the following information is submitted by the MHP. The EQRO then considers the information during the review:

- **Detailed descriptions of two PIPs. The PIP Outline is sent to each MHP to aid them in determining areas to include in the descriptions. The MHP is asked to include other pertinent information as well that indicates the overall findings and changes in processes in response to the PIP findings.**
- **The current QI Work Plan, QI Work Plan Evaluation, Quality Improvement Committee (QIC) meeting minutes from the last year.**
- **A list of current cultural competence goals and cultural competence committee meeting minutes from the last year.**
- **A list of surveys of beneficiaries conducted within the last year.**
- **A current, detailed MHP organizational chart.**
- **A list of current MHP strategic initiatives.**
- **Timeliness Self-Assessment**
- **Response to the Prior Year Recommendations**

- **An updated ISCA**

Additional information on EQRO related monitoring activity can be found in section III.1 pages ~~53-56~~) (insert correct page number in final draft).

Frequency of use: **Annual**

How it yields information about the area(s) being monitored: **The EQRO completes a report on each MHP after the review. These reports provide concrete information on the validity of MHP PIPs, the State/MHP performance measurements and MHP information system capability including recommendations tailored to each MHP's situation.**

The EQRO will be completing quarterly PIP status reports on all active PIPs within the state. These reports shall include:

- **Issuance of the PIP Guidelines for Plans or update existing PIP approval guidelines to the county MHPs.**
- **Development of a PIP Validation Tool.**
- **Provision of training and technical assistance to county MHPs and SMHS subcontracting providers on the PIP Guidelines.**
- **Review of county MHP, small group and statewide PIPs.**
- **Evaluation of each county MHP's PIPs in clinical and non-clinical areas.**
- **Measurement of each county MHP's PIP performance using objective indicators.**
- **Evaluation of each county MHP's implementation of PIP system interventions to achieve improvement in quality.**
- **Evaluation of effectiveness of the MHP's PIP interventions.**
- **Planning and initiation of activities for increasing and sustaining PIP improvment**

The EQRO also provides a written statewide annual report incorporating the findings of the performance measures validation activities, PIP validation activities, ISCA and input from clients and family members. This report:

- **Includes a detailed technical review that describes the manner in which data from all activities were aggregated and analyzed.**
- **Includes various analyses of Medi-Cal approved claims**
- **Addresses the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data;**
- **Outlines MHP performance in the four areas of Quality, Access, Timeliness and Outcomes.**
- **Includes an assessment of MHP's strengths and weaknesses with respect to the quality, timeliness and access to specialty mental health services furnished to the Medi-Cal beneficiaries by MHP's, including strengths and weaknesses on these issues from a cultural competency perspective.**

- **Includes recommendations representing the combined perspectives from the clinical/program lead, information systems reviewer, and consumer/family member consultant.**
- **Includes comparison to relevant national quality standards for Medicaid programs or comparable commercial products.**
- **Includes a public presentation of the report done via an electronic web based presentation or whatever means is agreed upon in writing by the contractor and the State.**

2. **Cultural Competence Plans**

Personnel responsible: **MHPs and State staff**

Detailed description of activity: **Title 9, CCR, Section 1810.410 requires each MHP have and comply with a Cultural Competence Plan (CCP) approved by the State and submit a CCP annually to the State. The 2010 CCP requirements are included in DMH Information Notices Nos. 10-02 and 10-17 which can be found on the DHCS website at: http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-2.pdf (see attachment-9) and http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-17.pdf (see attachment 10**

During the 9th waiver period, the department will implement the revised Cultural Competence Plan Requirements (CCPRs) in the beginning months of 2015. The process will be such that Mental Health Plan (MHP) staff will submit new Cultural Competence Plans (CCPs) to the department six (6) months after the MHPs have been informed about the submission requirements via an Information Notice. Then a review team of three, preferably a DHCS staff, an Ethnic Services Manager (ESM) and a Client/Family Member will review the plans for content. The reviewers will receive a training conducted by staff from the California Institute of Behavioral Health Services (CIBHS). After the review process, the MHPs will receive feedback on their plans and may have to provide additional information to the department.

While the MHP staff are preparing the plans, DHCS staff will provide technical assistance (TA) and work with the MHPs via conference call and/ or webinar, so that the cultural competence plans can be completed and reviewed in a timely fashion. Currently monthly TA calls/webinars are planned to provide MHP staff with necessary information to guide the process.

Finally, DHCS will establish a permanent Cultural Competence Advisory Committee and enlist subject matter experts' expertise to consolidate and streamline the current CCP criteria even more. A membership selection process will determine the composition. Members will include representation from client/family members, provider organizations, MHP and departmental staff as well as subject matter experts in the field of cultural competence.

~~DHCS is developing a plan to move forward with review of the CCPRs during waiver period 8. This plan includes collaboration with the newly established Office of Health Equity (OHE) located at the California Department of Public Health (DPH) to provide guidance on reducing mental health disparities to vulnerable communities. This collaboration will be strengthened through an interagency agreement between the two departments which will outline the process by which the departments will jointly work together to achieve the highest level of mental health for culturally, ethnically, linguistically, and geographically isolated communities. The collaboration will entail sharing resources to allow for appropriate CCPR developments and updates with monitoring through the triennial compliance reviews. In addition, the department will enlist input from subject matter experts and interested stakeholders to develop a robust CCPR process. Finally, DHCS is in the process of hiring additional staff to work on reviews of cultural competence plans and other related tasks.~~

Frequency of use: ~~As determined by the State~~ Annually

How it yields information about the area(s) being monitored: The county CCPs provide the State with baseline race and ethnicity data by county and enable MHPs to identify issues around disparities within their system. The CCP update approval process provides information on the MHP's progress in improving cultural competence and provides an opportunity for immediate feedback to the MHPs on problem areas. TA will be provided to MHPs regarding the problem areas to prepare MHPs for the upcoming review. DHCS will require MHPs to provide updates and evidences regarding the problem areas.

CCPRs include access to mental health services by race, ethnicity, gender and language in order to reduce disparities; MHPs are required to report on their workforce, provider networks, and population needs. Among other requirements, access needs to be provided through an effective 24/7 telephone language line as well as the availability of beneficiary informing materials in the MHP's respective threshold languages.

~~The CCP update approval process provides information on the MHP's progress in improving cultural competence and provides an opportunity for immediate feedback to the MHPs on problem areas.~~

3. Advisory Groups

~~a)~~ Strategy 1: Compliance Advisory Committee (CAC)

Personnel responsible: State staff

Detailed Description of Activity: As specified in W&I Code, Section 5614, the State shall have representatives from relevant stakeholders including, but not limited to local mental health departments, local mental health boards and commissions,

private and community based providers, consumers, family members and advocates.

The CAC plays a very significant role in the establishment of the annual Compliance Review Protocol tool which includes the following elements:

- **Access**
- **Authorization**
- **Beneficiary protection**
- **Funding, reporting and contracting requirements**
- **Target populations and array of services**
- **Interface with physical health care**
- **Provider relations**
- **Program Integrity**
- **Quality improvement**
- **Chart review—non-hospital services**
- **Chart review—sd/mc hospital services**
- ~~**Utilization review—sd/mc hospital services**~~
- ~~**Therapeutic behavioral services**~~

Annual meetings are held with CAC members and state staff to review drafts of the annual Compliance Review Protocol for specialty mental health services. The CAC recommendations are taken under consideration and incorporated into the protocol as deemed appropriate. The collaborative ongoing partnership between CAC and the State has ensured that local mental health departments meet statutory and regulatory requirements for the provision of publicly funded community health services.

The State will continue with the plan and practice of consultation and collaboration with the CAC ~~in FY 2013-2015~~ annually in 2015-2020 regarding the Compliance Review Protocol.

Strategy 2: Cultural Competence Advisory Committee

***Personnel responsible:* State staff**

***Detailed Description of Activity:* DHCS will establish a permanent Cultural Competence Advisory Committee and enlist subject matter experts' expertise to consolidate and streamline the current CCP criteria even more. A membership selection process will determine the composition. Members will include representation from client/family members, provider organizations, MHP and departmental staff as well as subject matter experts in the field of cultural competence.**

~~b)~~ Strategy 3: California Mental Health Planning Council (CMHPC)

2/23/2015: Awaiting Updated Information

4. Provider Appeals

Personnel responsible: **MHPs and State staff**

Strategy 1: Inpatient Service Treatment Authorization Requests (TAR) State Appeals: FFS Hospitals

Detailed description of activity: **MHPs are required to have a provider problem resolution process pursuant to CCR, Title 9, Section 1850.305.**

When the appeal concerns a dispute about payment for emergency psychiatric inpatient hospital services, the providers may appeal to the State if the MHP denies the appeal in whole or in part. Appeals to the State are generally referred to as "State/second-level TAR appeals." A review fee is assessed for each State/second-level TAR appeal filed. The fee is charged to the MHP if the State reverses the MHP's initial denial or to the provider if the State upholds the MHP's initial denial. If there is a split decision the fee is prorated according to the number of days decided in each party's favor. ~~The FFP share (50 percent of collected TAR appeal review fees are reflected on DHCS Administrative Costs invoices. DHCS' MHSD codes any TAR appeal review fee adjustments as line 7 for increasing costs and line 10B for decreasing costs. As with any other overpayments, the State has one (1) year from the discovery of any overpayment to refund the federal share of these fees.~~

Frequency of use: **Providers determine the frequency of appeals filed. For example, from July 2010 to December 31, 2012 ~~P~~providers filed an average of 10 ten State second level TAR appeals each month~~. in the period from July 2010, to December 31, 2012~~. This was a decrease from the period ~~from~~ July 1, 2009 through June 30, 2010 when an average of 22 State second level TAR appeals were filed per month.**

How it yields information about the area(s) being monitored: **The second-level TAR appeal process provides the State with information about the effectiveness of the MHP's post-service authorization system for psychiatric inpatient hospital services.**

Strategy 2: Appeals re ~~EPSDT Services~~ Specialty Mental Health Services

Detailed description of activity: **In accordance with CCR Title 9 sections 1810.203.5 and 1850.3~~50~~ 05, the State has established a progressive appeals process that includes a two-level (informal and formal) appeal process. ~~through which~~ MHPs and other legal entity providers may appeal claims that were disallowed for services delivered to EPSDT beneficiaries pursuant to the State's review of the MHP or other provider's client records. DHCS is currently promulgating regulations which will govern the formal appeals process for EPSDT and anticipates having them in place during the ~~8th~~ 9th waiver period.**

Frequency of use: **During the next ~~two fiscal years (July 1, 2013-June 30,~~ waiver period. (July 1, 2015 – June 30, 2020) ~~2015)~~, it is anticipated that overall approximately ~~wo formal appeals will be processed~~. 50 inpatient appeals, 50 outpatient appeals and 12 EPSDT appeals will be processed.**

How it yields information about the area(s) being monitored: **The ~~EPSDT~~ appeals process provides the State with information regarding specific chart documentation concerns of providers delivering ~~EPSDT~~ SMHS services.**

5. **County Support Unit**

Personnel responsible: **State staff**

Detailed description of activity: **County Support Unit (CSU) staff function as the central point of contact for the MHP, by providing technical assistance to the MHP and when necessary referring the MHP to other resources within or outside DHCS.**

Staff provides assistance via phone, e-mail and onsite visits as necessary. Technical assistance may involve clarifying information contained in policy documents, statutes and/or regulations, review of key documents and participation in regional Quality Improvement Committees. Examples of the areas in which the assigned staff will provide technical assistance include beneficiary protection, Medi-Cal billing, implementation plan revisions, quality improvement work plans

Participation in triennial reviews
CSU staff has increased monitoring efforts before during and after each Triennial Program Oversight and Compliance Review conducted by the DHCS Program Oversight and Compliance Branch to ensure that plans of corrections from the previous reviews have been implemented and to provide technical assistance, if necessary. During the waiver period, CSU staff will attend the onsite triennial reviews.. After the review, CSU staff will offer assistance to MHPs in implementing plans of correction required by the review and contact the MHPs as needed to monitor the status of the plans of correction following the review.

On an ongoing basis, evidence of correction will be collected to ensure corrective measures continue to be implemented, and the MHPs improve their procedures to ensure they are complying with state and federal requirements. When barriers to MHP implementation of their plans of correction are identified, CSU staff will continue to provide technical assistance and share successful practices from other MHPs until ongoing compliance can be assured

Critical areas of focus for technical assistance
In the new waiver period, CSU staff will focus technical assistance activities on areas of DHCS and CMS concern, including 24/7 access lines, systems to track timeliness of access, Treatment Authorization Requests adjudicated within 14 days, systems for logging grievance and appeal information, and provider certification and re-

certification. Examples of technical assistance activities will include conference calls, webinars, Information Notices, and focused interaction between CSU staff and key MHP contact persons.

Specific to the 24/7 access line, CSU collects and updates information from all the MHPs on the mechanisms used in each county to meet the linguistic access requirements, both during business hours and after hours. This information will assist DHCS to organize our technical assistance calls on 24/7 access line issues such as linguistic capability, answering mechanisms during business hours and after hours, access line scripts, and MHP internal test call frequency and scripts.

Quality Improvement Plans
County Support staff will request that MHPs submit Quality Improvement Work Plans which include evidence of internal MHP monitoring activities in key areas such as grievance and appeals, performance improvement projects, and mechanisms to assess the accessibility of services. The work plans will be reviewed and DHCS will provide feedback and technical assistance where necessary for each MHP. CSU staff will collaborate with DHCS Quality Assurance staff by attending the MHP QI Committee meetings and regional meetings of QI Coordinators. This will allow the state to provide ongoing monitoring and assistance to increase MHP quality improvement programs.

~~During the waiver period, County Support staff will participate when possible in the exit conferences for the triennial reviews conducted by the DHCS Program Oversight and Compliance Branch. County Support staff will offer assistance to MHPs in implementing plans of correction required by the review and contact the MHPs as needed to monitor the status of the plans of correction following the review.~~

County Support staff will review the draft and final EQRO reports for assigned MHPs. Staff will contact the MHPs as needed to monitor the status of implementing EQRO recommendations and the MHP's Performance Improvement Projects.

Frequency of use: **Daily and ongoing**

How it yields information about the area(s) being monitored: **The assignment of ~~County Support~~ CSU staff to each MHP provides the MHPs with a single point of contact with whom to raise issues of concern and obtain technical assistance, and provides the State with an individual who knows specifics about the operation of particular MHPs. The direct, personalized relationship between State staff and MHPs allows the State to monitor the MHPs activities, be aware of MHP concerns and offer assistance.**

CSU tracking of county information related to system reviews, 24/7 access line processes and other areas of MHP performance yields additional detail about the areas being monitored and changes made over time leading to improved

performance. When problems are identified that would present barriers to the MHP compliance with state and federal requirements, DHCS staff provides technical assistance and recommendations as soon as the challenges are noted.

DRAFT