# ANNUAL REVIEW PROTOCOL FOR SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES


CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

## FISCAL YEAR 2022-2023

AUDITS AND INVESTIGATIONS DIVISION

MEDICAL REVIEW BRANCH

BEHAVIORAL HEALTH COMPLIANCE SECTION

Ver. 06/14/2022

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## INTRODUCTION

DHCS is committed to ensuring that every beneficiary has access to high-quality, safe, and reliable service at the right level of care, when it is needed. In pursuit of this goal, the Medi-Cal Behavioral Health Division (MCBHD) and the Audits and Investigations Division (A&I) work collaboratively to update the review protocol on an annual basis to ensure County Mental Health Plans (MHPs) are in compliance with regulatory and contractual requirements and their obligations to their beneficiaries.

MHP obligations are outlined in the MHP Contract, codified in regulations, and are periodically updated in Behavioral Health Information Notices (BHINs).

## ENFORCEMENT AND CONSEQUENCES FOR NON-COMPLIANCE/TECHNICAL ASSISTANCE AND TRAINING

This annual update to the DHCS review protocol serves to notify the MHPs that if DHCS determines that an MHP is out of compliance with State or Federal laws or regulations, or the terms of the contract between the MHP and DHCS, then DHCS may take any or all of the following actions[1]:

(1) Require that the MHP develop a corrective action plan (CAP).[2] The CAP must include the following information:
   a. Description of corrective actions, including milestones.
   b. Timeline for implementation and/or completion of corrective actions.
   c. Proposed (or actual) evidence of correction that will be submitted to DHCS.
   d. Mechanisms for monitoring the effectiveness of corrective actions over time. If the CAP is determined to be ineffective, the MHP should propose an alternate CAP to DHCS.
   e. Description of corrective actions required of the MHP's contracted providers to address findings.

(2) Temporarily withhold all or a portion of payments due to the MHP from the DHCS.[3]

(3) Impose civil monetary sanctions.[4]

(4) Terminate the contract with the MHP.[5]

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[1] See WIC, §§ 14197.7, 14713, subd. (b); Cal. Code Regs. (CCR), tit. 9, § 1810.380, subd. (a).
[2] WIC, § 14197.7, subd. (d).
[3] *Id.*, subd. (o).
[4] *Id.*, subds. (d)(6), (e).
[5] *Id.*, subd. (a).

(5) Other authorized actions pursuant to Welfare and Institutions Code Section 14197.7, subdivision (d).

If DHCS determines that an action should be taken, DHCS shall provide the MHP with a written Notice of Noncompliance.[6] The Notice of Noncompliance shall include:

(1) A description of the violation(s).

(2) A description of any corrective action required by DHCS and time limits for compliance.

(3) A description of any and all proposed actions by DHCS, and any related appeal rights.

The MHP may appeal, in writing:

1. A Notice of Non-Compliance (referred as “Finding Report”) to DHCS within 15 working days after the date of receipt of the notice, setting forth relevant facts and arguments. DHCS must grant or deny the appeal in whole or in part within 30 calendar days after receipt of the appeal. DHCS must suspend any proposed action until DHCS has acted on the MHP's appeal.



[6] See WIC, § 14197.7, subd. (h).

## LIST OF ABBREVIATIONS

| | | | |
|---|---|---|---|
| 24/7 | 24 HOURS A DAY/SEVEN DAYS A WEEK | MHS | MENTAL HEALTH SERVICES |
| APP | AID PAID PENDING | MHSA | MENTAL HEALTH SERVICES ACT |
| BHIN | BEHAVIORAL HEALTH INFORMATION NOTICE | MOE | MAINTENANCE OF EFFORT |
| CAP | CORRECTIVE ACTION PLAN | MOU | MEMORANDUM OF UNDERSTANDING |
| CCC | CULTURAL COMPETENCE COMMITTEE | N | NON-COMPLIANCE, FINDING OF |
| CCPR | CULTURAL COMPETENCE PLAN REQUIREMENTS | NOABD | NOTICE OF ADVERSE BENEFIT DETERMINATION |
| CCR | CALIFORNIA CODE OF REGULATIONS | NPPES | NATIONAL PLAN AND PROVIDER ENUMERATION SYSTEM |
| CDPH | CALIFORNIA DEPARTMENT OF PUBLIC HEALTH | OIG LEIE | OFFICE OF INSPECTOR GENERAL'S LIST OF EXCLUDED INDIVIDUALS/ENTITIES |
| C.F.R. | CODE OF FEDERAL REGULATIONS | P | PARTIAL COMPLIANCE |
| CFT | CHILD AND FAMILY TEAM | P&Ps | POLICIES AND PROCEDURES |
| CMS | CENTERS FOR MEDICARE AND MEDICAID SERVICES | PCP | PRIMARY CARE PHYSICIAN |
| CPPP | COMMUNITY PROGRAM PLANNING PROCESS | PHI | PROTECTED HEALTH INFORMATION |
| DHCS | DEPARTMENT OF HEALTH CARE SERVICES | PIP | PERFORMANCE IMPROVEMENT PROJECTS |
| DMH | [FORMER] DEPARTMENT OF MENTAL HEALTH (STATE) | PLW | PROFESSIONAL LICENSING WAIVER |

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|---|---|---|---|
| EPSDT | EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT | POA | POINT OF AUTHORIZATION |
| EPLS/SAM | EXCLUDED PARTIES LIST SYSTEM/SYSTEM OF AWARD MANAGEMENT | POS | PERFORMANCE OUTCOMES SYSTEM |
| FY | FISCAL YEAR | PSC | PERSONAL SERVICES COORDINATOR |
| ICC | INTENSIVE CARE COORDINATION | QAPI | QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT |
| IHBS | INTENSIVE HOME BASED SERVICES | QIC | QUALITY IMPROVEMENT COMMITTEE |
| IMD | INSTITUTION FOR MENTAL DISEASES | RCL | RATE CLASSIFICATION LEVEL |
| IN | INFORMATION NOTICE | SD/MC | SHORT-DOYLE/MEDI-CAL |
| ITWS | INFORMATION TECHNOLOGY WEB SERVICES | SMHS | SPECIALTY MENTAL HEALTH SERVICES |
| LEP | LIMITED ENGLISH PROFICIENCY | SNF | SKILLED NURSING FACILITY |
| LPHA | LICENSED PRACTITIONER OF THE HEALING ARTS | STP | SPECIALIZED TREATMENT PROGRAM |
| LPT | LICENSED PSYCHIATRIC TECHNICIAN | TAR | TREATMENT AUTHORIZATION REQUEST |
| LVN | LICENSED VOCATIONAL NURSE | TBS | THERAPEUTIC BEHAVIORAL SERVICES |
| M/C | MEDI-CAL | TDD/TTY | TELECOMMUNICATION DEVICE FOR THE DEAF/ TEXT TELEPHONE/TELETYPE |
| MCE | MEDICAL CARE EVALUATION | TFC | THERAPEUTIC FOSTER CARE |
| MCP | MEDI-CAL MANAGED CARE PLAN | UM/UR | UTILIZATION MANAGEMENT/ UTILIZATION REVIEW |
| MHP | MENTAL HEALTH PLAN | WIC | WELFARE AND INSTITUTIONS CODE |
| MHRC | MENTAL HEALTH REHABILITATION CENTER | Y | YES – IN-COMPLIANCE |

# Category 1: Network Adequacy and Availability of Services

| 1.1 AVAILABILITY OF SPECIALTY MENTAL HEALTH SERVICES (SMHS) | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 1.1.1 | The MHP shall provide, or arrange and pay for, the following medically necessary covered SMHS to beneficiaries who meet access criteria for receiving the following SMHS:<br>• Mental health services;<br>• Medication support services;<br>• Day treatment intensive;<br>• Day rehabilitation;<br>• Crisis intervention;<br>• Crisis stabilization;<br>• Adult residential treatment services;<br>• Crisis residential treatment services;<br>• Psychiatric health facility services;<br>• Intensive Care Coordination (for beneficiaries under the age of 21);<br>• Intensive Home Based Services (for beneficiaries under the age of 21);<br>• Therapeutic Behavioral Services (for beneficiaries under the age of 21);<br>• Therapeutic Foster Care (for beneficiaries under the age of 21);<br>• Children's crisis residential programs;<br>• Psychiatric Inpatient Hospital Services;<br>• Targeted Case Management.<br>• For beneficiaries under the age of 21, the Contractor shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code (Welf. & Inst. Code 14184.402 (d)). (MHP Contract, Ex. A, Att. 2) | • P&Ps<br>• MHP Implementation Plan<br>• Program descriptions of required services<br>• Service availability data<br>• Service utilization data<br>• Executed provider subcontracts for required services<br>• POS data |

| 1.1 AVAILABILITY OF SPECIALTY MENTAL HEALTH SERVICES (SMHS) | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 1.1.2 | The MHP must make SMHS available 24/7, when medically necessary. (42 C.F.R. § 438.206(c)(1)(iii).) | • P&Ps<br>• Program description for 24/7 services available to beneficiaries<br>• Program descriptions for pre-crisis/ crisis services<br>• Subcontracted provider contract(s) for 24/7 services available to beneficiaries |
| 1.1.3 | The MHP shall implement mechanisms to assess the accessibility of services within its service delivery area. This shall include:<br>1. The assessment of responsiveness of the MHP's 24-hour toll-free telephone number,<br>2. Access to after-hours care.<br>(MHP Contract, Ex. A, Att. 8, sec.(2)(B).) | • P&Ps<br>• 24/7 access line monitoring data<br>• Corrective action taken to improve accessibility of services<br>• Timeliness compliance monitoring data/report |
| 1.1.4 | The MHP shall require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the MHP shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the MHP, or another MHP. (42 C.F.R. § 438.206(c)(1)(ii); MHP Contract, Ex. A, Att. 8, sec. (4)(A)(3).) | • P&Ps<br>• Boilerplate provider contract (excerpts only) with hours of operation requirements |

| 1.1 AVAILABILITY OF SPECIALTY MENTAL HEALTH SERVICES (SMHS) | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 1.1.5 | The MHP shall establish mechanisms to ensure that network providers comply with the timely access requirements. (42 C.F.R. § 438.206(c)(1)(iv); MHP Contract, Ex. A, Att. 8, sec. (4)(A)(5)-(7).).)<br>1. The MHP shall monitor network providers regularly to determine compliance with timely access requirements. (42 C.F.R. § 438.206(c)(1)(v).)<br>2. The MHP shall take corrective action if a network provider fails to comply with timely access requirements. (42 C.F.R. § 438.206(c)(1)(vi).) | • P&Ps<br>• Service Request Log, including subcontractors' data<br>• Timeliness compliance monitoring data/report<br>• Corrective actions taken to improve timely access to care and services<br>• Evidence that the MHP is monitoring timely access (tracking tools, database, etc.)<br>• Boilerplate provider contract requiring compliance with timely access standards |

| 1.2 CHILDREN'S SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 1.2.1 | The MHP must provide ICC and IHBS to all children and youth who meet criteria for beneficiary access to SMHS as medically necessary. Membership in the Katie A. subclass is not a prerequisite to receiving ICC and IHBS. (BHIN 21-073; Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, (3rd ed., Jan. 2018), pp. 7-12.) | • P&Ps<br>• ICC/IHBS service criteria<br>• ICC/IHBS screening tool<br>• ICC/IHBS training materials<br>• List of beneficiaries receiving ICC/IHBS<br>• Referral forms<br>• Referral tracking mechanisms/logs of children/youth including those who are receiving ICC/IHBS<br>• POS data |
| 1.2.2 | The MHP has an affirmative responsibility to determine if children and youth who meet criteria for beneficiary access to SMHS need ICC and IHBS. (BHIN 21-073; Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, (3rd ed., Jan. 2018), p. 9.) | • P&Ps<br>• ICC/IHBS service criteria<br>• ICC/IHBS screening tool<br>• ICC/IHBS training materials<br>• List of beneficiaries receiving ICC/IHBS<br>• Referral forms<br>• Referral tracking mechanisms/logs of children/youth including those who are receiving ICC/IHBS |

| 1.2 CHILDREN'S SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 1.2.3 | The MHP must maintain and monitor network of appropriate providers that is supported by written agreements and is sufficient to provide access to ICC and IHBS services for all eligible beneficiaries, including those with limited English proficiency. (42 C.F.R. § 438.206(b)(1) and (c)(3); see MHP Contract, Ex. A, Att. 8, sec. (3)(B).) | • P&Ps<br>• ICC/IHBS provider subcontracts<br>• ICC/IHBS provider capacity monitoring data/report<br>• POS data |
| 1.2.4 | The Child and Family Team (CFT) composition should, as appropriate, includes a representative of the MHP and/or a representative from the mental health treatment team. (Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, (3rd ed., Jan. 2018), p. 17.) | • P&Ps<br>• CFT minutes<br>• CFT sign-in sheets/evidence of list of attendees<br>• CFT training materials<br>• CFT tracking mechanism/log |
| 1.2.5 | The MHP is responsible to convene a CFT for children and youth who are receiving ICC, IHBS, or TFC, but who are not involved in the child welfare or juvenile probation systems. (Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, (3rd ed., Jan. 2018), p. 19.) | • P&Ps<br>• CFT minutes<br>• CFT sign-in sheets/evidence of list of attendees<br>• CFT training materials<br>• CFT tracking mechanism/log |

| 1.2 CHILDREN'S SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 1.2.6 | There is an established ICC Coordinator, as appropriate, who serves as the single point of accountability. (Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, (3rd ed., Jan. 2018), pp. 23-24.) | • P&Ps<br>• List of ICC Coordinators<br>• ICC Coordinator's job description/duty statement<br>• ICC Coordinator training material<br>• List of beneficiaries receiving ICC/IHBS and their assigned ICC coordinators<br>• Sample of medical records indicating ICC Coordinators' involvement in strength and needs assessment every 90 days, including referral, linkage, monitoring, and follow-up activities<br>• CFT minutes/sign-in sheet or other evidence indicating ICC Coordinator's involvement in making recommendations |
| 1.2.7 | The MHP must provide Therapeutic Foster Care (TFC) services to all children and youth who meet beneficiary access criteria for SMHS as medically necessary. (BHIN 21-073; Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, (3rd ed., Jan. 2018), p. 34.) | • P&Ps<br>• TFC criteria<br>• TFC screening tool<br>• List of beneficiaries receiving TFC<br>• TFC provider subcontract<br>• POS data<br>• TFC training materials |

| 1.2 | CHILDREN'S SERVICES | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 1.2.8 | The MHP has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need TFC. (BHIN 21-073; Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, (3rd ed., Jan. 2018), p. 11.) | • P&Ps<br>• TFC criteria<br>• TFC screening tool<br>• List of beneficiaries receiving TFC<br>• TFC training materials |

| 1.3 | PROVIDER SELECTION AND MONITORING | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 1.3.1 | The MHP shall provide a beneficiary's choice of the person providing services to the extent possible and appropriate. (CCR, tit. 9, § 1830.225, subd. (a); 42 C.F.R. § 438.3(l); MHP Contract, Ex. A., Att. 2, sec. 2(G).) | • P&Ps<br>• Change of provider request form<br>• Change of provider request log with dispositions<br>• Change of provider request samples |
| 1.3.2 | Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide beneficiaries an opportunity to change persons providing outpatient SMHS. (CCR, tit. 9, §1830.225, subd (b).) | • P&Ps<br>• Change of provider request form<br>• Change of provider request log with dispositions<br>• Change of provider request samples |
| 1.3.3 | The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract. (42 C.F.R. § 438.12(a)(1); MHP Contract, Ex. A, Att. 8, sec. 7(F).) | • P&Ps<br>• Evidence of written notice<br>• Template for written notice |

| 1.3 PROVIDER SELECTION AND MONITORING | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 1.3.4 | The MHP shall certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810.435. (MHP Contract, Ex. A, Att. 8, sec. 8(D).) | • P&Ps<br>• MHP's certification and re-certification protocol/forms<br>• Evidence of onsite certification/recertification of contracted organizational providers or county owned and operated self-certified providers<br>• Sample of completed certification documentation<br>• Mechanism to track certification and re-certification status of providers |
| 1.3.5 | The MHP shall monitor the performance of its subcontractors on an ongoing basis for compliance with the terms of the MHP contract and shall subject the subcontractors' performance to periodic formal review. (MHP Contract, Ex. A, Att. 8, sec. 8(M).) | • Evidence of subcontractor monitoring<br>• Monitoring/performance reports<br>• Provider Subcontracts<br>• Subcontractor's audit/monitoring tools<br>• Chart documentation manual<br>• Chart documentation training material<br>• Chart audit reports |
| 1.3.6 | If the MHP identifies deficiencies or areas of improvement with respect to the performance of its subcontractors, the MHP and the subcontractor shall take corrective action. (MHP Contract, Ex. A, Att. 8, sec. 8(M).) | • Corrective Action tracking mechanism/log<br>• Samples of Corrective Actions taken with outcomes |

# Category 2: Care Coordination and Continuity of Care

| 2.1 COORDINATION OF CARE REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 2.1.1 | The MHP shall coordinate the services the MHP furnishes to the beneficiary between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. (MHP Contract, Ex. A, Att. 10, sec. 1(A)(2); 42 C.F.R. § 438.208(b)(2)(i)-(iv); CCR, tit. 9, § 1810.415.) | • P&Ps<br>• Sample of medical records showing evidence of discharge planning activities and coordination of care across delivery systems<br>• Any other evidence the MHP coordinates care and ensures warm hand-offs across delivery systems |
| 2.1.2 | The MHP shall coordinate the services the MHP furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in Fee-for-service Medi-Cal, from community and social support providers, and other human services agencies used by its beneficiaries. (MHP Contract, Ex. A, Att.10, sec. 1(A)(2); 42 C.F.R. § 438.208(b)(2)(i)-(iv); CCR, tit. 9, § 1810.415.) | • P&Ps<br>• Beneficiary medical records<br>• Evidence of discharge planning activities<br>• Any other evidence the MHP coordinates care and ensures warm hand-offs across delivery systems |

| 2.2 CONTINUITY OF CARE | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 2.2.1 | Continuity of Care written notifications to the beneficiary must comply with Title 42 of the Code of Federal Regulations, part 438.10(d) and include the following:<br>○ The MHP's denial of the beneficiary's continuity of care request;<br>○ A clear explanation of the reasons for the denial;<br>○ The availability of in-network SMHS;<br>○ How and where to access SMHS from the MHP;<br>○ The beneficiary's right to file an appeal based on the adverse benefit determination; and,<br>○ The MHP's beneficiary handbook and provider directory. (MHSUDS IN No. 18-059; see MHP Contract, Ex. A, Att. 10, sec. 1(F); 42 CFR § 438.62(b)(2).) | • P&Ps<br>• Sample of continuity of care requests<br>• Continuity of care request tracking mechanism/log<br>• Evidence of notification to beneficiaries<br>• Continuity of care request data/monitoring report<br>• Beneficiary notification template |
| 2.2.2 | The MHP must notify the beneficiary, and/or the beneficiary's authorized representative, 30 calendar days before the end of the continuity of care period about the process that will occur to transition a beneficiary's care at the end of the continuity of care period. (MHSUDS IN No. 18-059; see MHP Contract, Ex. A, Att. 10, sec. 1(F); 42 CFR § 438.62(b)(2).) | • P&Ps<br>• Sample of continuity of care requests<br>• Continuity of care request tracking mechanism/log<br>• Evidence of notification to beneficiaries<br>• Continuity of care request data/monitoring report<br>• Beneficiary notification template |

# Category 3: Quality Assurance and Performance Improvement

| 3.1 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 3.1.1 | The MHP has a written description of the Quality Assessment and Performance Improvement (QAPI) Program that:<br>1. Clearly defines its structure and elements,<br>2. Assigns responsibility to appropriate individuals, and<br>3. Adopts or establishes quantitative measures to assess performance and identify and prioritize areas for improvement.<br>(MHP Contract, Ex. A, Att. 5, sec. 1(C); 42 C.F.R. § 438.330(a)(1), (e)(2).) | • P&Ps<br>• QAPI Program Description |
| 3.1.2 | The MHP evaluates the impact and effectiveness of the QAPI Program annually and updates the Program as necessary. (MHP Contract, Ex. A, Att. 5, sec. 1(C); CCR, tit. 9, § 1810.440, subd. (a)(6).) | • P&Ps<br>• Annual QAPI Program Evaluation |
| 3.1.3 | The MHP shall conduct performance-monitoring activities throughout the MHP's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances. (MHP Contract, Ex. A, Att. 5, sec. 1(E); 42 C.F.R. § 438.330(a)(1), (e)(2).) | • P&Ps<br>• QAPI work plan<br>• QAPI work plan evaluation<br>• Evidence of performance monitoring<br>• Performance data reports |
| 3.1.4 | The MHP shall have mechanisms to detect both underutilization and overutilization of services. (MHP Contract, Ex. A, Att. 5, sec. 1(F); 42 C.F.R. § 438.330(b)(3).) | • P&Ps<br>• QAPI Work Plan<br>• Utilization data reports<br>• EQRO Reports |

| 3.1 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 3.1.5 | The MHP has mechanisms to assess beneficiary/family satisfaction by surveying beneficiary/family satisfaction at least annually. (MHP Contract, Ex. A, Att. 5, sec. 1(G).) | • P&Ps<br>• Annual Beneficiary/Family Satisfaction survey questions sample<br>• Survey Results |
| 3.1.6 | The MHP has mechanisms to assess beneficiary/family satisfaction by evaluating beneficiary grievance, appeals and State hearings at least annually. (MHP Contract, Ex. A, Att. 5, sec. 1(G).) | • P&Ps<br>• QIC agenda/minutes<br>• Analysis of grievances, appeals, and fair hearings<br>• QAPI work plan evaluation |
| 3.1.7 | The MHP shall inform providers of the beneficiary/family satisfaction activities. (MHP Contract, Ex. A, Att. 5, sec. 1(G).) | • P&Ps<br>• Sample notification to providers<br>• Beneficiary/family satisfaction survey reports |
| 3.1.8 | The MHP shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be:<br>1. Under the supervision of a person licensed to prescribe or dispense medication.<br>2. Performed at least annually.<br>3. Inclusive of medications prescribed to adults and youth.<br>(MHP Contract, Ex. A, Att. 5, sec. 1(H).) | • P&Ps<br>• Prescribing practice guidelines<br>• Medication practice monitoring tools<br>• Medication practice monitoring results/report<br>• Medication practice training materials |

| 3.1 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 3.1.9 | The MHP has mechanisms to address meaningful clinical issues affecting beneficiaries system-wide. (MHP Contract, Ex. A, Att. 5, sec. 1(I).) | • P&Ps<br>• QAPI work plan<br>• QAPI work plan evaluation<br>• QIC agenda/minutes<br>• Clinical performance improvement projects<br>• Corrective action plan or process improvement projects for system-wide improvement |
| 3.1.10 | The MHP has mechanisms to:<br>1. Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.<br>2. Take appropriate follow-up action when such an occurrence is identified.<br>3. Evaluate the results of the intervention at least annually.<br>(MHP Contract, Ex. A, Att. 5, sec. 1(J).) | • P&Ps<br>• QAPI Work plan<br>• QAPI work plan evaluation<br>• QIC agendas/minutes<br>• Quality of care concerns monitoring mechanism/tools/log<br>• Quality of care concern monitoring results |

| 3.2 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 3.2.1 | The MHP has a QAPI Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. (MHP Contract, Ex. A, Att. 5, sec. 2(A).) | • P&Ps<br>• QAPI Work Plan<br>• QAPI Work Plan evaluations<br>• QIC agendas and/or minutes |

| 3.2 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 3.2.2 | The QAPI Work Plan includes evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited State hearings, provider appeals, and clinical records review. (MHP Contract, Ex. A, Att. 5, sec. 2(a)(1).) | • P&Ps<br>• QAPI Work Plan<br>• QAPI Work Plan evaluations<br>• QIC agendas and/or minutes |
| 3.2.3 | The QAPI Work Plan includes evidence that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service. (MHP Contract, Ex. A, Att. 5, sec. 2(a)(2).) | • P&Ps<br>• QAPI Work Plan<br>• QAPI Work Plan evaluations<br>• QIC agendas and/or minutes |
| 3.2.4 | The QAPI work plan includes a description of completed and in-process QAPI activities, including:<br>1) Monitoring efforts for previously identified issues, including tracking issues over time.<br>2) Objectives, scope, and planned QAPI activities for each year.<br>3) Targeted areas of improvement or change in service delivery or program design.<br>(MHP Contract, Ex. A, Att. 5, sec. 2(a)(3).) | • P&Ps<br>• QAPI Work Plan<br>• QAPI Work Plan evaluations<br>• QIC agendas and/or minutes |
| 3.2.5 | The QAPI work plan includes a description of mechanisms the MHP has implemented to assess the accessibility of services within its service delivery area, including goals for:<br>1) Responsiveness for the MHPs 24-hour toll-free telephone number.<br>2) Timeliness for scheduling of routine appointments.<br>3) Timeliness of services for urgent conditions.<br>4) Access to after-hours care.<br>(MHP Contract, Ex. A, Att. 5, sec. 2(a)(4).) | • P&Ps<br>• QAPI Work Plan<br>• QAPI Work Plan evaluations<br>• QIC agendas and/or minutes<br>• Accessibility monitoring tools<br>• Accessibility monitoring results<br>• Test Call Procedures<br>• Test Call/Call Answering Services Provider Contracts |

| 3.2 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 3.2.6 | The QAPI work plan includes evidence of compliance with the requirements for cultural competence and linguistic competence. (MHP Contract, Ex. A, Att. 5, sec. 2(a)(5).) | • P&Ps<br>• QAPI Work Plan<br>• QIC agendas and/or minutes<br>• Cultural Competence Plan |

| 3.3 QUALITY IMPROVEMENT COMMITTEE (QIC) | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 3.3.1 | The MHP shall establish a QIC to review the quality of SMHS provided to beneficiaries. (MHP Contract, Ex. A, Att. 5, sec. (3)(B).) | • P&Ps<br>• QIC Charter<br>• QIC agendas/minutes<br>• QIC sign-in sheets/Evidence of list of attendees<br>• Evidence of planning, design and execution activities |
| 3.3.2 | The QIC shall:<br>a. Recommend policy decisions.<br>b. Review and evaluate the results of QI activities, including performance improvement projects (PIPs).<br>c. Institute needed QI actions.<br>d. Ensure follow-up of QI processes.<br>e. Document QI committee meeting minutes regarding decisions and actions taken.<br>(MHP Contract, Ex. A, Att. 5, sec. 3(B).) | • P&Ps<br>• QIC Charter<br>• QIC agendas/minutes<br>• QIC sign-in sheets/Evidence of list of attendees<br>• Evidence of planning, design and execution activities |

| 3.3 QUALITY IMPROVEMENT COMMITTEE (QIC) | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 3.3.3 | The MHP QAPI program includes active involvement in the planning, design and execution of the QI Program by the Contractor's practitioners and providers, beneficiaries who have accessed SMHS through the Contractor, family members, legal representatives, or other persons similarly involved with beneficiaries (MHP Contract, Ex. A, Att. 5, sec. 3(E); CCR, tit. 9, § 1810.440(a)(2)(A)-(C).) | • P&Ps<br>• Agendas/minutes including list of attendees Evidence of planning, design, and execution activities |
| 3.3.4 | The MHP collects and analyzes data to measure against the goals or prioritized areas of improvement that have been identified. (MHP Contract, Ex. A, Att. 5, sec. 3(F)(1).) | • P&Ps<br>• Data to measure against identified goals<br>• QIC agenda/minutes<br>• QAPI Work Plan<br>• QAPI Work Plan evaluations<br>• Quality Improvement data reports |
| 3.3.5 | The MHP obtains input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services. (MHP Contract, Ex. A, Att. 5, sec. 3(F)(4).) | • P&Ps<br>• QIC agenda/minutes<br>• Satisfaction Surveys<br>• Sample of input received |

| 3.4 | UTILIZATION MANAGEMENT | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 3.4.1 | The MHP's Utilization Management (UM) Program shall evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively. (MHP Contract, Ex. A, Att. 6, sec. 1(B).) | • P&Ps<br>• UM evaluation tools<br>• UM evaluation and audits results<br>• Chart audit tools<br>• Chart audit results/reports<br>• UMC minutes<br>• QIC minutes |
| 3.4.2 | The MHP shall operate a UM program that is responsible for assuring that beneficiaries have appropriate access to SMHS. (MHP Contract, Ex. A, Att. 6, sec. 1(A); CCR, tit. 9, § 1810.440, subd. (b).) | • P&Ps<br>• UM evaluation tools<br>• UM evaluation and audits results<br>• Chart audit tools<br>• Chart audit results/reports<br>• UMC minutes<br>• QIC minutes |

| 3.5 PRACTICE GUIDELINES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 3.5.1 | The MHP has practice guidelines, which meet the requirements of the MHP Contract.<br>(MHP Contract, Ex. A, Att. 5, sec. 6(A); 42 C.F.R. § 438.236(b); CCR, tit. 9, § 1810.326.) | • P&Ps<br>• MHP's Practice Guidelines<br>• Provider Manual<br>• Provider Contract Boilerplate<br>• Practice Guideline Training Materials |
| 3.5.2 | The MHP shall disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.<br>(MHP Contract, Ex. A, Att. 5, sec. 6(c); 42 C.F.R. § 438.236(c); CCR, tit. 9, § 1810.326.) | • P&Ps<br>• MHP's Practice Guidelines<br>• Provider Manual<br>• Provider Contract Boilerplate<br>• Practice Guideline Training Materials |
| 3.5.3 | The MHP take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted.<br>(MHP Contract, Ex. A, Att. 5, sec. 6(D); 42 C.F.R. § 438.236(d); CCR, tit. 9, § 1810.326.) | • P&Ps<br>• MHP's Practice Guidelines<br>• Provider Manual<br>• Provider Contract Boilerplate<br>• Practice Guideline Training Materials |

# Category 4: Access and Information Requirements

| 4.1 LANGUAGE AND FORMAT REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 4.1.1 | The MHP shall provide all written materials for potential beneficiaries and beneficiaries in a font size no smaller than 12 point. (42 C.F.R. § 438.10(d)(6)(ii); MHP Contract, Ex. A, Att. 11, sec. 3(A).) | • P&Ps<br>• Beneficiary Intake packet |
| 4.1.2 | The MHP shall make its written materials that are critical to obtaining services available in the prevalent non-English languages in the county. This includes, at a minimum, the following:<br>1) appeal and grievance notices,<br>2) denial and termination notices, and,<br>3) MHP's mental health education materials,<br>(MHP Contract, Ex. A, Att. 11, sec. 3(C); 42 C.F.R. § 438.10(d)(3).) | • P&Ps<br>• Documentation of threshold languages in the county<br>• Appeal and Grievance notices<br>• Denial and termination notices<br>• MHP's mental health education materials (Posted notices and signage, other brochures, etc.) |

| 4.1 LANGUAGE AND FORMAT REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 4.1.3 | The MHP shall post (1) a Department-approved nondiscrimination notice and (2) language taglines in a conspicuously visible font size in English in the top 15 non-English languages in the State, and any other languages, as determined by the Department, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request auxiliary aids and services, including materials in alternative formats. The nondiscrimination notice and taglines, shall include the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit for obtaining these services, and shall be posted as follows:<br><br>a. In conspicuous physical locations where the Contractor interacts with the public;<br>b. On the internet website published and maintained by the MHP, in a manner that allows beneficiaries, prospective beneficiaries, and members of the public to easily locate the information; and<br>c. Informational notices targeted to beneficiaries and members of the public (including notices of action). (42 C.F.R. § 438.10(d)(2)-(3); Welf. & Inst. Code, § 14727(b), (c)(1)-(2).)<br>(MHP Contract, Ex. A, Att. 11, sec. 3(F)(1)(a-c) | • P&Ps<br>• Informing materials with tag line in the threshold languages in the county.<br>• Informing materials in large print<br>• Posted beneficiary informing materials |
| 4.1.4 | The MHP shall notify beneficiaries, prospective beneficiaries, and members of the public that written translation is available in prevalent languages free of cost and shall notify beneficiaries how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); WIC, § 14727, subd. (a)(1); CCR, tit. 9, § 1810.410, subd. (e)(4).) | • P&Ps<br>• Posted informing materials |

| 4.1 | LANGUAGE AND FORMAT REQUIREMENTS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 4.1.5 | The MHP has a mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and/or culturally appropriate field testing). (DMH IN No. 10-02, encl. 1, p. 23.) | • P&Ps<br>• Contracts with vendors for translated materials<br>• Sample of translated materials tested for accuracy |

| 4.2 | 24/7 ACCESS LINE AND WRITTEN LOG OF REQUESTS FOR SMHS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 4.2.1 | The MHP provides training for staff responsible for the statewide toll-free 24-hour telephone line to ensure linguistic capabilities. (CCR, tit. 9, § 1810.410, subd. (c) (4) & (e).) | • P&Ps<br>• Documentation of training plan<br>• Training records<br>• Training materials |
| 4.2.2 | Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:<br><br>1) The MHP provides 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.<br>2) The toll-free telephone number provides information to beneficiaries about how to access SMHS, including SMHS required to assess whether criteria for beneficiary access to SMHS are met.<br>3) The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.<br>4) The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.<br>(CCR, tit. 9, chapter 11, §§ 1810.405, subd. (d); 1810.410, subd. (e)(1).) | • DHCS test call worksheets<br>• P&Ps<br>• Contracts/documentation of vendors providing language access for 24/7 statewide toll free line<br>• Test call scripts<br>• MHP test call results |

| 4.2 | 24/7 ACCESS LINE AND WRITTEN LOG OF REQUESTS FOR SMHS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 4.2.3 | The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. (CCR, tit. 9, § 1810.405, subd. (f).) | • P&Ps<br>• Written log(s) of initial requests/service request log / access line call log |
| 4.2.4 | The written log(s) contain the following required elements:<br>a) Name of the beneficiary.<br>b) Date of the request.<br>c) Initial disposition of the request.<br>(CCR, tit. 9, § 1810.405, subd. (f). | • P&Ps<br>• DHCS test call results<br>• Written log(s) of initial requests/service request log/ access line call log |

| 4.3 | CULTURAL COMPETENCE REQUIREMENTS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 4.3.1 | The MHP has updated its Cultural Competence Plan annually in accordance with regulations. (CCR, tit. 9, § 1810.410, subds. (c)-(d); MHP Contract, Ex. A, Att. 7, sec. 2(B).)<br><br>Regarding the MHP's Cultural Competence Committee (CCC): | • P&Ps<br>• Cultural Competence Plan |
| 4.3.2 | The MHP has a CCC or other group that addresses cultural issues and has participation from cultural groups that is reflective of the community. (DMH IN No. 10-02, encl. 1, p. 14.) | • P&Ps<br>• CCC organizational chart / committee membership roster<br>• CCC charter<br>• Cultural Competence Plan<br>• CCC annual report |

| 4.3 CULTURAL COMPETENCE REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 4.3.3 | The CCC completes its Annual Report of CCC activities as required in the CCPR. (DMH IN No. 10-02, encl. 1, p. 15.) | • P&Ps<br>• CCC Annual Report(s)<br>• Cultural Competence Plan<br>• QIC minutes |
| 4.3.4 | The MHP has evidence of policies, procedures, and practices that demonstrate the CCC activities include the following:<br>a) Participation in overall planning and implementation of services at the county.<br>b) Provides reports to the Quality Assurance and/or the Quality Improvement Program.<br>(DMH IN No. 10-02, encl. 1, p. 14.) | • P&Ps<br>• CCC organizational chart<br>• CCC agenda and minutes<br>• Cultural Competence Plan<br>• QIC review documentation<br>• CCC annual report<br>• Evidence of CCC reports provided to QIC<br>• QIC agenda/minutes |

| 4.3 CULTURAL COMPETENCE REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 4.3.5 | Regarding the MHP's plan for annual cultural competence training necessary to ensure the provision of culturally competent services:<br>1) There is a plan for cultural competency training for the administrative and management staff of the MHP.<br>2) There is a plan for cultural competency training for persons providing SMHS employed by or contracting with the MHP.<br>3) There is a process that ensures that interpreters are trained and monitored for language competence (e.g., formal testing).<br>(CCR, tit. 9, § 1810.410, subd. (c)(4).) | • P&Ps<br>• CCC organizational chart<br>• CCC agenda and minutes<br>• Cultural Competence Plan<br>• CCC annual report<br>• Training records (Administrative and management staff; Persons providing SMHS employed by or subcontracted with MHP)<br>• Training records for interpreters and bilingual staff<br>• Training materials/handouts<br>• Training calendars<br>• Cultural Competence Training plan |
| 4.3.6 | The MHP has evidence of the implementation of training programs to improve the cultural competence skills of staff and contract providers. (See CCR, tit. 9, § 1810.410, subd. (c)(4)). | • P&Ps<br>• Documentation of tracking mechanisms to ensure all staff receive required annual training including subcontracted providers<br>• MHP provider contract |
| 4.3.7 | The MHP has a listing of SMHS and other MHP services available for beneficiaries in their primary language by location of the services, pursuant to Section 1810.360. (CCR, tit. 9, § 1810.410, subd. (c)(3).) | • P&Ps<br>• List of SMHS and other MHP services available in different languages |

| 4.3 CULTURAL COMPETENCE REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 4.3.8 | The MHP provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language. (CCR, tit. 9, § 1810.410, subd. (e)(2)(B).) | • P&Ps<br>• Sample of referrals made to the provider that have interpreter services in the threshold language |

# Category 5: Coverage and Authorization of Services

| 5.1 AUTHORIZATION – GENERAL REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.1.1 | The MHP shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate. (MHP Contract, Ex. A, Att. 6, sec. 2(A)(2); 42 C.F.R. § 438.210(b)(2)(i)-(ii).) | • P&Ps<br>• Sample Requests for Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Utilization Management review tools (chart review tools, inter-rater reliability tools, etc.)<br>• Approver Licenses and signature list |
| 5.1.2 | The MHP shall establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services<br>(BHIN No. 22-017; 42 C.F.R., § 438.210(b)(1).) | • P&Ps<br>• Sample Requests for Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log |
| 5.1.3 | The MHP may manage authorizations directly or delegate authorization functions to an administrative entity, consistent with federal law, and the MHP contract for SMHS.<br>(BHIN No. 22-017) | • P&Ps<br>• Documentation of any Delegation of Authorization Functions, i.e., contract, MOU |

| 5.1 AUTHORIZATION – GENERAL REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.1.4 | The MHP shall have any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs. (MHP Contract, Ex. A, Att. 6, sec. 2(A)(3); 42 C.F.R. § 438.210(b)(3).)<br><br>No individual other than a licensed physician or a licensed mental health professional who is competent to evaluate the specify clinical issues involved in the SMHS requested by a beneficiary or a provider, may deny, or modify a request for authorization of SMHs for a beneficiary for reasons related to medical necessity<br>(BHIN No. 22-016; 42 C.F.R., § 438.210(b)(3).) | • P&Ps<br>• Sample Requests for Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Utilization Management review tools (chart review tools, inter-rater reliability tools, etc.)<br>• Approver Licenses and signature list |
| 5.1.5 | A decision to modify an authorization request shall be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and shall include a clear and concise explanation of the reasons for the MHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. The decision shall also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision.<br>(BHIN No. 22-016; Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(4); 42 C.F.R. § 438.210(c).) | • P&Ps<br>• Sample Requests for Authorization<br>• Sample authorization requests with MHP decision to modify the request<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• NOABDs |

| 5.1 AUTHORIZATION – GENERAL REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.1.6 | The MHP shall notify the requesting provider, and give the beneficiary written notice of any decision by the MHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (MHP Contract, Ex. A, Att. 12, sec. 9(G); 42 C.F.R. § 438.210(c).) | • P&Ps<br>• Sample Requests for Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Sample of written notification to the beneficiaries |
| 5.1.7 | The MHP shall provide or arrange and pay for all medically necessary covered SMHS in a sufficient amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. (42 C.F.R., § 438.210(a)(3)(i); MHP Contract, Ex. A, Att. 2, sec. 2(D).) | • P&Ps<br>• Sample Requests for Authorizations<br>• Payment Authorization<br>• Checklist/tools/tracking mechanism/log |
| 5.1.8 | The MHP shall not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the beneficiary. The MHP may deny services based on Welfare and Institutions Code sections 14184.402, subdivisions (a), (c), and (d), 14059.5; and departmental guidance and regulation. (42 C.F.R. § 438.210(a)(2) and (3); MHP Contract, Ex. A, Att. 2, sec. 2(D).) | • P&Ps<br>• Sample Requests for Authorizations<br>• Sample Authorization Requests that have been denied<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list |

| 5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.2.1 | MHPs are required to operate a utilization management (UM) program that ensures beneficiaries have appropriate access to SMHS. The UM program must evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively, such as through prior or concurrent authorization review procedures. (BHIN 22-017; Cal. Code Regs., tit. 9, § 1810.440(b); 42 C.F.R. § 438.210 (a)(4), (b)(1),(2).) | • P&Ps<br>• Sample Requests for Authorization<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list |
| 5.2.2 | MHPs shall establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services in accordance with BHIN 22-017 and shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate.<br><br>Authorization procedures and utilization management criteria shall:<br>a. Be based on medical necessity and consistent with current evidence-based clinical practice guidelines, principles, and processes;<br>b. Be developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their respective scopes of practice ;<br>c. Be evaluated, and updated as necessary, and at least annually, and be disclosed to the MHP's beneficiaries and network providers.<br><br>(BHIN 22-017; 42 C.F.R., § 438.210(b)(1); 42 CFR, § 438.210(b)(2)(i-ii).) | • P&Ps<br>• Sample Authoizations for Psychiatric Inpatient Hospital Services<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Mechanisms used by MHP to ensure consistent application of authorization review criteria |

| 5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.2.3 | MHPs may manage authorizations directly or delegate authorization functions to an administrative entity, consistent with federal law and the MHP's contract for SMHS. (BHIN 22-017) | • P&Ps<br>• Documentation of any Delegation of Authorization Functions, i.e., contract, MOU |
| 5.2.4 | MHPs shall comply with the following communication requirements:<br>1. Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;<br>2. Disclose to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting them online;<br>3. Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,<br>4. Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.<br><br>(BHIN 22-017; 42 C.F.R., § 438.10(g)(2)(iv).) | • P&Ps<br>• Sample Requests for Authorization<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list<br>• Sample notifications to DHCS and contracting providers |

| 5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.2.5 | Concurrent Review<br>• In the absence of an MHP referral, MHPs shall conduct concurrent review of treatment authorizations following the first day of admission to a facility through discharge. MHPs may elect to authorize multiple days, based on the beneficiary's mental health condition, for as long as the services are medically necessary.<br><br>(BHIN 22-016.) | • P&Ps<br>• Sample Requests for Authorizations<br>• Documented evidence of concurrent review of treatment authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list |
| 5.2.6 | Telephone Access:<br>• MHPs shall maintain telephone access to receive Psychiatric Inpatient Hospital or Psychiatric Health Facility (PHF) admission notifications and initial authorization requests 24-hours a day and 7 days a week<br>(BHIN 22-017; Welf. & Inst. Code, § 14197.1; Health & Saf. Code, §§ 1367.01(i), 1371.4(a).) | • P&Ps<br>• Evidence of telephone access to receive admission notifications and initial authorization requests<br>• Tracking mechanism/call log |

| 5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.2.7 | Review of initial authorization request**.**<br>• The MHP shall decide whether to grant, modify or deny the hospital or PHFs initial treatment authorization request and communicate the decision to the requesting hospital or PHF per managed care requirements for expedited authorizations following receipt of all information specified in I.a. of BHIN 22-017. *The MHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and not later than 72 hours after receipt of the request for services*<br>(BHIN 22-017) | • P&Ps<br>• Sample Requests for Authorization<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Documented evidence of making expedited authorization decision and providing notice not later than 72 hours after receipt of request for services<br>• Approver Licenses and signature list |
| 5.2.8 | Continued Stay Authorization Request<br>• When medically necessary for the beneficiary, before the end of the initial authorization period, or a subsequent authorization period, the hospital or PHF shall submit a continued-stay- authorization request for a specified number of days to the responsible county MHP.<br>• The responsible county MHP *shall issue a decision on a hospital or PHF's continued-stay-authorization request within 24-hours of receipt of the request and all information reasonably necessary to make a determination.*<br><br>(BHIN 22-017; Welf. & Inst. Code 14197.1; Health & Saf. Code, §1367.01(h)(2).) | • P&Ps<br>• Sample Requests for Authorization<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Documented evidence of the MHP issuing a decision on continued-stay-authorization requested within 24-hours of receipt of the request and all information reasonably needed to make a determination |

| 5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.2.9 | Adverse Decision, Clinical Consultation, Plan of Care, and Appeal.<br>1. While LMHPs/LPHAs may review authorization requests and issue approvals within their scope of practice, all MHP decisions to modify or deny a treatment request shall be made by a physician or psychologist who has appropriate expertise in addressing the beneficiary's behavioral health needs. A psychologist may modify or deny a request for authorization for treatment for a patient only if a psychologist admitted the patient to the hospital. A psychologist may modify or deny a request for authorization for treatment consistent with the psychologist's scope of practice.<br>2. A decision to modify an authorization request shall be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and shall include a clear and concise explanation of the reasons for the MHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.<br>3. The decision shall also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision.<br>4. If a MHP modifies or denies an authorization request, the MHP shall notify the beneficiary in writing of the adverse benefit determination before the hospital discontinues inpatient psychiatric hospital services. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.<br>5. If a MHP denies a hospital's authorization request, the MHP must work with the treating provider to develop a plan of care. Services shall not be | • P&Ps<br>• Sample Requests for Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Sample of notification to the beneficiary<br>• Approver Licenses and signature list<br>• Sample written notifications to providers<br>• Sample written notification to beneficiaries<br>• Sample of Plans of Care developed by the MHP and Treating Provider under these circumstances<br>• Sample of provider appeals<br>• Sample NOABDs |

| 5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.2.9 cont. | 6. discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical, including behavioral health, needs of the beneficiary.<br>7. If the MHP and treating hospital provider do not agree on a plan of care, the provider, may, on behalf of the beneficiary and with the beneficiary's written consent, appeal the denial to the MHP, as provided for in the notice of adverse benefit determination. The hospital may provide the adverse benefit determination to the beneficiary after receiving notice from the MHP.<br><br>(BHIN 22-017; Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(e) & (h)(3-4); 42 C.F.R. §§ 431.213(c); 438.404; 438.210(b)(3) & (c); 431.213(c); MHSUDS IN 18-010E.) | |
| 5.2.10 | Authorizing Administrative Days<br>1. In order to conduct concurrent review and authorization for administrative day service claims, the MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status.<br>2. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized.<br>3. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive | • P&Ps<br>• Sample Requests for Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list<br>• Sample of documentation showing required contacts were made<br>• Mechanisms to ensure proper contacts are made (training material, tracking |

| 5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS | | |
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| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| | authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented.<br>4. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.<br>5. MHPs may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact.<br><br>(BHIN 22-017; Cal. Code Regs., tit. 9, § 1820.230; Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400.) | mechanism/log, desk procedure, check-list etc.) |
| 5.2.11 | MHPs must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). MHPs may not require prior authorization.<br>1. If the MHP refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the MHP specifies the parameters (e.g., number of days authorized) of the authorization.<br>2. The MHP must then re-authorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services.<br>(BHIN 22-016.) | • P&Ps<br>• Sample Requests for Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list |

| 5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.2.12 | The MHP may extend the timeframe for making an authorization decision for up to 14 additional calendar days, if the following conditions are met:<br>1. The beneficiary, or the provider, requests an extension; or, 2. The MHP justifies (to the State upon request), and documents, a need for additional information and how the extension is in the beneficiary's interest.<br>(BHIN 22-016) | • P&Ps<br>• Documented evidence of concurrent review of treatment authorizations in absence of an MHP Referral |
| 5.2.13 | MHPs must establish and implement policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS<br>a. MHPs <u>may not require</u> prior authorization for the following services/service activities:<br>i. Crisis Intervention;<br>ii. Crisis Stabilization;<br>iii. Mental Health Services, including initial assessment;<br>iv. Targeted Case Management;<br>v. Intensive Care Coordination; and,<br>vi. Peer Support Services<br>vii. Medication Support Services.<br>b. Prior authorization or MHP referral <u>is required</u> for the following services:<br>i. Intensive Home-Based Services<br>ii. Day Treatment Intensive<br>iii. Day Rehabilitation<br>iv. Therapeutic Behavioral Services<br>v. Therapeutic Foster Care<br>(BHIN 22-016.) | • P&Ps<br>• Sample Requests for Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list |

| 5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.2.14 | MHPs must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.<br>(BHIN 22-016.) | • P&Ps<br>• Sample Requests for Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list |
| 5.2.15 | For cases in which a provider indicates, or the MHP determines, that following the standard timeframe could jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. (42 C.F.R. § 438.210(d)(2)(i); BHIN 22-016.) | • P&Ps<br>• Sample Requests for Authorizations<br>• Sample Expedited Authorization Decisions<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list |
| 5.2.16 | The MHP referral or prior authorization shall specify the amount, scope, and duration of treatment that the MHP has authorized.<br>(BHIN 22-016.) | • P&Ps<br>• Sample Referrals or Prior Authorizations specifying amount, scope, and duration of treatment the MHP has authorized<br>• Sample Requests for Authorizations |

| 5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.2.16 cont. | | • Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list |
| 5.2.17 | MHPs must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). MHPs may conduct retrospective authorization of SMHS under the following limited circumstances:<br>○ Retroactive Medi-Cal eligibility determinations;<br>○ Inaccuracies in the Medi-Cal Eligibility Data System;<br>○ Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dually-eligible beneficiaries; and/or,<br>○ Beneficiary's failure to identify payer.<br>(BHIN 22-016; BHIN 22-017.) | • P&Ps<br>• Sample Requests and Determinations for Retrospective Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list |
| 5.2.18 | In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements. (BHIN 22-016.) | • P&Ps<br>• Sample Requests for Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list<br>• Evidence of communication to the individual who received |

| 5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.2.18 cont. | | services, or to the individual's designee, within 30 days of receipt of information reasonably necessary to make the determination |

| 5.3 PRESUMPTIVE TRANSFER | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.3.1 | Pursuant to (W&I) Code Section 14717.1(b)(2)(F), the MHP has a procedure for expedited transfers within 48 hours of placement of the foster child or youth outside of the county of original jurisdiction. (MHSUDS IN No. 18-027; see WIC § 14717.1, subd. (b)(2)(F), (g).) | • P&Ps<br>• Sample of expedited transfer documentations<br>• Sample Requests for Authorizations<br>• Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list |
| 5.3.2 | A waiver processed based on an exception to presumptive transfer shall be contingent upon the MHP in the county of original jurisdiction demonstrating an existing contract with a SMHS provider, or the ability to enter into a contract within 30 days of the waiver decision, and the ability to deliver timely SMHS directly to the foster child. That information shall be documented in the child's case plan. (WIC § 14717.1, subd. (d)(6).) | • P&Ps<br>• Sample of the case documentations showing executed contract within 30 days of the waiver decision<br>• Presumptive transfer waiver tracking mechanism/log<br>• Sample Requests for Authorizations |

| 5.3 PRESUMPTIVE TRANSFER | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.3.2 cont. | | • Payment Authorization Checklist/tools/tracking mechanism/log<br>• Approver Licenses and signature list |

| 5.4 NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD) REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.4.1 | The MHP must provide beneficiaries with a NOABD under the following circumstances:<br>1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit. (42 C.F.R. § 438.400(b)(1))<br>2) The reduction, suspension or termination of a previously authorized service. (42 C.F.R. § 438.400(b)(2))<br>3) The denial, in whole or in part, of a payment for service. (42 C.F.R. § 438.400(b)(3))<br>4) The failure to provide services in a timely manner. (42 C.F.R. § 438.400(b)(4))<br>5) The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (42 C.F.R. § 438.400(b)(5)).<br>6) The denial of a beneficiary's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, co-insurance, and other beneficiary financial liabilities. (42 C.F.R. § 438.400(b)(7)) | • P&Ps<br>• NOABD Samples<br>• NOABD tracking mechanism |

| 5.4 NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD) REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 5.4.1 cont. | (42 C.F.R. § 438.404(a); MHSUDS IN No. 18-010E; MHP Contract, Ex. A, Att. 12, sec. 10(A)(1)-(6).) | |
| 5.4.2 | The MHP includes the following information in the NOABD:<br>1. The adverse benefit determination of the MHP has made or intends to make. (42 C.F.R. § 438.404(b)(1).)<br>2. The reason for the adverse benefit determination. (42 C.F.R. § 438.404(b)(2).)<br>3. The right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (42 C.F.R. § 438.404(b)(2).)The beneficiary's right to file, and the procedures for exercising, an appeal or an expedited appeal with the MHP, including information about exhausting the MHPs one level of appeal and the right to request a State Hearing after receiving notice that the adverse benefit determination is upheld. (42 C.F.R. § 438.404(b)(3)-(6).)<br>4. The circumstances under which an appeal process can be expedited and how to request it. (42 C.F.R. § 438.404(b)(5).)<br>5. The beneficiary's right to have benefits continue pending resolution of the appeal and how to request that benefits be continued, and the circumstances under which a beneficiary may be required to pay the costs of those services. (42 C.F.R. § 438.404(b)(6).<br><br>MHSUDS IN No. 18-010E; MHP Contract, Ex. A, Att. 12, sec. 10(A).) | • P&Ps<br>• NOABD samples<br>• NOABD templates |

# Category 6: Beneficiary Rights and Protections

| 6.1 GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.1.1 | The MHP shall have a grievance and appeal system in place for beneficiaries. The grievance and appeal system shall be implemented to handle appeals of adverse benefit determinations and grievances, and shall include processes to collect and track information about them. The MHP's beneficiary problem resolution processes shall include:<br><br>1) A grievance process;<br>2) An appeal process; and,<br>3) An expedited appeal process.<br><br>(MHP Contract, Ex. A, Att. 12, sec. 1(A); CCR, tit. 9, § 1850.205, subd. (b)(1)-(3); 42 C.F.R. §§ 438.228(a), 438.402(a); MHSUDS IN No. 18-010E.) | • P&Ps<br>• Definition of the grievance and appeal<br>• Problem resolution informing materials<br>• Problem resolution forms<br>• Link to the MHP website with problem resolution informing materials<br>• Grievance and Appeal training materials |
| 6.1.2 | The MHP shall ensure that each beneficiary has adequate information about the MHP's problem resolution processes by taking at least the following actions:<br>1) Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all MHP provider sites. Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of State Hearings after the exhaustion of an appeal or expedited appeal process, including information that a State Hearing may be requested whether or not the beneficiary has received a notice of adverse | • P&Ps<br>• Definition of the grievance and appeal<br>• Problem resolution informing materials<br>• Problem resolution forms<br>• Link to the MHP website with problem resolution informing materials<br>• Grievance and Appeal training materials |

| 6.1 GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.1.2 cont. | 2) benefit determination. For the purposes of this Section, a MHP provider site means any office or facility owned or operated by the MHP or a provider contracting with the MHP at which beneficiaries may obtain SMHS. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(1)(b); CCR, tit. 9, §§ 1850.205, subd. (c)(1)(B); 1850.210.)<br>3) Make available forms that may be used to file grievances, appeals, and expedited appeals and self-addressed envelopes that beneficiaries can access at all MHP and network provider sites without having to make a verbal or written request to anyone. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(1)(c); CCR, tit. 9, § 1850.205, subd. (c)(1)(C).)<br>4) Give beneficiaries any reasonable assistance in completing the forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(1)(d); 42 C.F.R. § 438.406(a); 42 C.F.R. § 438.228(a).) | |

| 6.1 GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.1.3 | The MHP shall allow beneficiaries to file grievances and request appeals. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(2); 42 C.F.R. § 438.402(c)(1).) | • P&Ps<br>• Definition of the grievance and appeal<br>• Problem resolution informing materials<br>• Problem resolution forms<br>• Link to the MHP website with problem resolution informing materials<br>• Grievance and Appeal training materials |
| 6.1.4 | The MHP shall have only one level of appeal for beneficiaries. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(2); 42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a).) | • P&Ps<br>• Definition of the grievance and appeal<br>• Problem resolution informing materials<br>• Problem resolution forms<br>• Link to the MHP website with problem resolution informing materials<br>• Grievance and Appeal training materials |

| 6.1 GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.1.5 | 1) The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(5); 42 C.F.R. § 438.406(b)(1); 42 C.F.R. § 438.228(a); CCR., tit. 9, § 1850.205(d)(4).)<br>2) The acknowledgment letter shall include the following:<br>a) Date of receipt<br>b) Name of representative to contact<br>c) Telephone number of contact representative<br>d) Address of MHP<br>(MHSUDS IN No. 18-010E.)<br>3) The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS IN No. 18-010E.) | • P&Ps<br>• Acknowledgement letter template<br>• Sample acknowledgement letters<br>• Grievance/Appeal/Expedited Appeal samples<br>• Grievance and Appeal training materials<br>• Grievance/Appeal tracking mechanism/log |
| 6.1.6 | The MHP shall allow a provider, or authorized representative, acting on behalf of the beneficiary and with the beneficiary's written consent to request an appeal, file a grievance, or request a State Hearing. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(6); 42 C.F.R. § 438.402(c)(1)(i)-(ii); CCR, tit. 9, § 1850.205, subd. (c)(2).) | • P&Ps<br>• Definition of the grievance and appeal<br>• Problem resolution informing materials<br>• Problem resolution forms<br>• Link to the MHP website with problem resolution informing materials<br>• Grievance and Appeal training materials |

| 6.1 GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS | | |
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| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.1.7 | At the beneficiary's request, the MHP shall identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the MHP is the person providing SMHS to the beneficiary requesting assistance, the MHP shall identify another individual to assist that beneficiary (MHP Contract, Ex. A, Att. 12, sec. 1(B)(8); CCR, tit. 9, § 1850.205, subd. (c)(4).) Assistance includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. (42 C.F.R. § 438.406(a).) | • P&Ps<br>• Definition of the grievance and appeal<br>• Problem resolution informing materials<br>• Problem resolution forms<br>• Link to the MHP website with problem resolution informing materials<br>• Grievance and Appeal training materials |
| 6.1.8 | The MHP shall not subject a beneficiary to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(9); CCR, tit. 9, § 1850.205, subd. (c)(5).) | • P&Ps<br>• Definition of the grievance and appeal<br>• Problem resolution informing materials<br>• Problem resolution forms<br>• Link to the MHP website with problem resolution informing materials<br>• Grievance and Appeal training materials |

| 6.1 GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS | | |
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| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.1.9 | The MHP's procedures for the beneficiary problem resolution processes shall maintain the confidentiality of each beneficiary's information. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(10); CCR, tit. 9, § 1850.205, subd. (c)(6).) | • P&Ps<br>• Definition of the grievance and appeal<br>• Problem resolution informing materials<br>• Problem resolution forms<br>• Link to the MHP website with problem resolution informing materials<br>• Grievance and Appeal training materials |
| 6.1.10 | The MHP shall include a procedure to transmit issues identified as a result of the grievance, appeal or expedited appeal processes to the MHP's Quality Improvement Committee, the MHP's administration or another appropriate body within the MHP's operations. The MHP shall consider these issues in the MHP's Quality Improvement Program, as required by CCR, title 9, section 1810.440, subd. (a)(5). (MHP Contract, Ex. A, Att. 12, sec. 1(B)(11); CCR, tit. 9, § 1850.205(c)(7).) | • P&Ps<br>• QIC minutes<br>• Grievance/Appeal/Expedited appeal analysis data/report<br>• QAPI work plan<br>• QAPI work evaluation |
| 6.1.11 | The MHP shall ensure that decision makers on grievances and appeals of adverse benefit determinations were not involved in any previous level of review or decision-making, and were not subordinates of any individual who was involved in a previous level of review or decision-making. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(12); 42 C.F.R. § 438.406(b)(2)(i); 42 C.F.R. § 438.228(a).) | • P&Ps<br>• Definition of the grievance and appeal<br>• Problem resolution informing materials<br>• Problem resolution forms<br>• |

| 6.1 GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.1.11 cont. | | • Link to the MHP website with problem resolution informing materials<br>• Grievance and Appeal training materials<br>• Grievance/Appeal/Expedited Appeal samples<br>• Grievance/Appeal/Expedited Appeal tracking mechanism/log |
| 6.1.12 | The MHP shall ensure that individuals making decisions on the grievances and appeals of adverse benefit determinations, have the appropriate clinical expertise, as determined by DHCS, in treating the beneficiary's condition or disease, if the decision involves an appeal based on a denial of medical necessity, a grievance regarding denial of a request for an expedited appeal, or if the grievance or appeal involves clinical issues. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(13); 42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a).) | • P&Ps<br>• Definition of the grievance and appeal<br>• Problem resolution informing materials<br>• Problem resolution forms<br>• Link to the MHP website with problem resolution informing materials<br>• Grievance and Appeal training materials<br>• Grievance/Appeal/Expedited Appeal samples<br>• Grievance/Appeal/Expedited Appeal tracking mechanism/log |

| 6.1 GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS | | |
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| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.1.13 | The MHP shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(15); 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).) | • P&Ps<br>• Definition of the grievance and appeal<br>• Problem resolution informing materials<br>• Problem resolution forms<br>• Link to the MHP website with problem resolution informing materials<br>• Grievance and Appeal training materials<br>• Grievance/Appeal/Expedited Appeal samples<br>• Grievance/Appeal/Expedited Appeal tracking mechanism/log |
| 6.1.14 | The MHP shall provide information to all beneficiaries, prospective beneficiaries, and members of the public on how to file a Discrimination Grievance with:<br>a) The MHP and the Department if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. (Welf. & Inst. Code § 14727(a)(4).)<br>b) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (Welf. & Inst. Code § 14727(a)(5).)<br>(MHP Contract, Ex. A, Att. 11, sec. 3(F)(3)(a-b).) | • P&Ps<br>• Beneficiary problem resolution informing materials<br>• Problem resolution forms<br>• Grievance training materials<br>• Grievance samples<br>• Grievance tracking mechanism/log |

| 6.1 GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| | For Discrimination Grievances: | |
| 6.1.15 | The MHP shall designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements, and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law. (Welf. & Inst. Code § 14727(a)(4); 45 C.F.R. § 84.7; 34 C.F.R. § 106.8; 28 C.F.R. § 35.107; see 42 U.S.C. § 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; (MHP Contract, Ex. A, Att. 12, sec. 4(A)(1).) | • P&Ps<br>• Beneficiary problem resolution informing materials<br>• Problem resolution forms<br>• Grievance training materials<br>• Grievance samples<br>• Grievance tracking mechanism/log |
| 6.1.16 | The MHP shall adopt procedures to ensure the prompt and equitable resolution of discrimination-related complaints. (Welf. & Inst. Code § 14727(a)(4); 45 C.F.R. § 84.7; 34 C.F.R. § 106.8; 28 C.F.R. § 35.107; see 42 U.S.C. § 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B.)<br><br>The MHP shall not require a beneficiary to file a Discrimination Grievance with the MHP before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights. (MHP Contract, Ex. A, Att. 12, sec. 4(A)(2).) | • P&Ps<br>• Beneficiary problem resolution informing materials<br>• Problem resolution forms<br>• Grievance training materials<br>• Grievance samples<br>• Grievance tracking mechanism/log |

| 6.1 GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS | | |
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| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.1.17 | Within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the MHP must submit the following information regarding the complaint to the DHCS Office of Civil Rights (see California Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B):<br>a) The original complaint.<br>b) The provider's or other accused party's response to the complaint.<br>c) Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of the MHP.<br>d) Contact information for the beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.<br>e) All correspondence with the beneficiary regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgment letter and resolution letter sent to the beneficiary.<br>f) The results of the MHPs investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.<br><br>(MHP Contract, Ex. A, Att. 12, sec. 4(A)(3).) | • P&Ps<br>• Beneficiary problem resolution informing materials<br>• Problem resolution forms<br>• Grievance training materials<br>• Grievance samples<br>• Grievance tracking mechanism/log |

| 6.2 HANDLING GRIEVANCES AND APPEALS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.2.1 | Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. (42 C.F.R. § 438.416(a); CCR, tit. 9, § 1850.205, subd. (d)(1); MHP Contract, Ex. A, Att. 12, sec. 2(A).) | • P&Ps<br>• Grievance/Appeal/Expedited Appeal samples<br>• Grievance/Appeal/Expedited Appeal tracking mechanism/log |
| 6.2.2 | Each record shall include, but not be limited to: a general description of the reason for the appeal or grievance the date received, the date of each review or review meeting, resolution information for each level of the appeal or grievance, if applicable, and the date of resolution at each level, if applicable, and the name of the covered person whom the appeal or grievance was filed. (42 C.F.R. § 438.416(b)(1)-(6); MHP Contract, Ex. A, Att. 12, sec. 2(A).) | • P&Ps<br>• Grievance/Appeal/Expedited Appeal samples<br>• Grievance/Appeal/Expedited Appeal tracking mechanism/log |
| 6.2.3 | Record in the grievance and appeal log or another central location determined by the MHP, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log. (CCR, tit. 9, § 1850.205, subd. (d)(2); MHP Contract, Ex. A, Att. 12, sec. 2(B).) | • P&Ps<br>• Grievance/Appeal/Expedited Appeal samples<br>• Grievance/Appeal/Expedited Appeal tracking mechanism/log |
| 6.2.4 | Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal. (CCR, tit. 9, § 1850.205, subd. (d)(3); MHP Contract, Ex. A, Att. 12, sec. 2(C).) | • P&Ps<br>• Grievance/Appeal/Expedited Appeal samples<br>• Grievance/Appeal/Expedited Appeal tracking mechanism/log |
| 6.2.5 | Identify in its grievance, appeal, and expedited appeal documentation, the roles and responsibilities of the MHP, the provider, and the beneficiary. (CCR, tit. 9, § 1850.205, subd. (d)(5); MHP Contract, Ex. A, Att. 12, sec. 2(D).) | • P&Ps<br>• Grievance/Appeal/Expedited Appeal samples<br>• Grievance/Appeal/Expedited Appeal tracking mechanism/log |

| 6.2 | HANDLING GRIEVANCES AND APPEALS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.2.6 | Provide notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal. (CCR, tit. 9, § 1850.205, subd. (d)(6); MHP Contract, Ex. A, Att. 12, sec. 2(E).) | • P&Ps<br>• Grievance/Appeal/Expedited Appeal samples<br>• Grievance/Appeal/Expedited Appeal tracking mechanism/log<br>• Example of provider notification |

| 6.3 | GRIEVANCE PROCESS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.3.1 | The MHP's grievance process shall, at a minimum:<br>Allow beneficiaries to file a grievance either orally, or in writing at any time with the MHP. (42 C.F.R. § 438.402(c)(2)(i), (c)(3)(i); MHP Contract, Ex. A, Att. 12, sec. 3(A).) | • P&Ps<br>• Grievance samples<br>• Grievance tracking mechanism/log |
| 6.3.2 | Resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the MHP receives the grievance. (42 C.F.R. § 438.408(a)-(b)(1); MHP Contract, Ex. A, Att. 12, sec. 3(C).) | • P&Ps<br>• Grievance samples<br>• Grievance tracking mechanism/log |
| 6.3.3 | Provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if they could not be contacted. (CCR, tit. 9, § 1850.206, subd. (c); MHP Contract, Ex. A, Att. 12, sec. 3(E).) | • P&Ps<br>• Grievance samples<br>• Grievance tracking mechanism/log<br>• NGR template |

| 6.3 GRIEVANCE PROCESS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.3.4 | Notify the beneficiary of the resolution of a grievance in a format and language that meets applicable notification standards. (42 C.F.R. § 438.408(d)(1); 42 C.F.R. § 438.10; MHP Contract, Ex. A, Att. 12, sec. 3(F).) | • P&Ps<br>• Grievance samples<br>• Grievance tracking mechanism/log<br>• NGR template |
| 6.3.5 | The MHP shall use a written Notice of Grievance Resolution (NGR) to notify beneficiary of the results of a grievance resolution which shall contain a clear and concise explanation of the Plan's decision. (MHSUDS IN No. 18-010E.) | • P&Ps<br>• Grievance samples<br>• Grievance tracking mechanism/log<br>• NGR template |

| 6.4 APPEAL PROCESS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.4.1 | The MHP's appeal process shall, at a minimum, allow a beneficiary, or a provider or authorized representative acting on the beneficiary's behalf, to file an appeal orally or in writing. The beneficiary may file an appeal within 60 calendar days from the date on the adverse benefit determination notice (42 C.F.R. § 438.402(c)(2)(ii), (c)(3)(ii); MHP Contract, Ex. A, Att. 12, sec. 5(A)(1).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |
| 6.4.2 | The MHP treats oral inquiries seeking to appeal an adverse benefit determination as appeals (to establish the earliest possible filing date for the appeal). The MHP requires a beneficiary who makes an oral appeal to subsequently submit a written, signed appeal, unless the beneficiary or the provider requests an expedited appeal. The date the MHP receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(18) and 5(A)(2); 42 C.F.R. §§ 438.402(c)(3)(ii); 438.406(b)(3).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |

| 6.4 APPEAL PROCESS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.4.3 | Resolve each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal. (42 C.F.R. § 438.408(a), (b)(2); MHP Contract, Ex. A, Att. 12, sec. 5(A)(3).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |
| 6.4.4 | Allow the beneficiary to have a reasonable opportunity to present evidence and testimony and make arguments of fact or law, in person and in writing. The MHP must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals specified in §438.408(b) and (c) in the case of expedited resolution. (42 C.F.R. § 438.406(b)(4); MHP Contract, Ex. A, Att. 12, sec. 1(B)(14).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |
| 6.4.5 | Provide the beneficiary and their representative the beneficiary's case file, including medical records, and any other documents and records, and any new or additional evidence considered, relied upon, or generated by the MHP in connection with the appeal of the adverse benefit determination, provided that there is no disclosure of the protected health information of any individual other than the beneficiary (42 C.F.R. § 438.406(b)(5); MHP Contract, Ex. A, Att. 12, sec. 5(A)(5).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |
| 6.4.6 | Provide the beneficiary and their representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. (42 C.F.R. § 438.406(b)(5); MHP Contract, Ex. A, Att. 12, sec. 1(B)(17) and 5(A)(6); see 42 C.F.R. § 438.408(b)-(c).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |
| 6.4.7 | Allow the beneficiary, their representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal. (42 CFR § 438.406(b)(6); MHP Contract, Ex. A, Att. 12, sec. 5(A)(7).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |

| 6.4 APPEAL PROCESS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.4.8 | The MHP includes in the written Notice of Appeal Resolution (NAR) results of the resolution process and the date the process was completed. (42 C.F.R. § 438.408(e)(1); MHP Contract, Ex. A, Att. 12, sec. 5(B)(1)-(2).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log<br>• NAR template |
| 6.4.9 | The MHP includes in the NAR the beneficiary's right to a State Hearing and the procedure to request one if the appeal resolution is not wholly in favor of the beneficiary. 42 C.F.R. § 438.408(e)(2)(i); MHP Contract, Ex. A, Att. 12, sec. 5(B)(3)(a).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log<br>• Beneficiary's right template |
| 6.4.10 | The MHP includes in the written notice of the appeal resolution the beneficiary's right to request and receive benefits while the State Hearing is pending, and how the beneficiary makes this request. (42 C.F.R. § 438.408(e)(2)(ii); MHP Contract, Ex. A, Att. 12, sec. 5(B)(3)(b).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log<br>• NAR template |
| 6.4.11 | The MHP's expedited appeal process shall, at a minimum:<br>Be used when the MHP determines or the beneficiary and/or the beneficiary's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, physical or mental health or ability to attain, maintain, or regain maximum function. (42 C.F.R. § 438.410(a); MHP Contract, Ex. A, Att. 12, sec. 6(B)(1).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |
| 6.4.12 | Allow the beneficiary to file the request for an expedited appeal orally without requiring the beneficiary to submit a subsequent written, signed appeal. (42 C.F.R. § 438.402(c)(3)(ii); MHP Contract, Ex. A, Att. 12, sec. 6(B)(2).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |

| 6.4 APPEAL PROCESS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.4.13 | Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. (42 C.F.R. § 438.410(b); MHP Contract, Ex. A, Att. 12, sec. 6(B)(3).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |
| 6.4.14 | Inform beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. The MHP must inform beneficiaries of this sufficiently in advance of the resolution timeframe for the expedited appeal. (42 CFR §§ 438.406(b)(4); 438.408(b)-(c); MHP Contract, Ex. A, Att. 12, sec. 6(B)(4).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log<br>• Example of the informing material |
| 6.4.15 | Resolve an expedited appeal and notify the affected parties in writing, as expeditiously as the beneficiary's health condition requires and no later than 72 hours after the MHP receives the appeal. (42 C.F.R. § 438.408(b)(3); MHP Contract, Ex. A, Att. 12, sec. 6(B)(5).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |
| 6.4.16 | Provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or their representative. The written notice shall meet the requirements of Section 1850.207(h) of Title 9 of the California Code of Regulations. (42 C.F.R. § 438.408(d)(2); CCR, tit. 9, § 1850.207(h); MHP Contract, Ex. A, Att. 12, sec. 6(B)(6).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |

| 6.4 APPEAL PROCESS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.4.17 | If the MHP denies a request for an expedited appeal resolution, the MHP shall:<br>a) Transfer the expedited appeal request to the timeframe for standard resolution of no longer than 30 calendar days from the day the MHP receives the appeal.<br>b) Make reasonable efforts to give the beneficiary and their representative prompt oral notice of the denial of the request for an expedited appeal.<br>(42 C.F.R. § 438.410(c)(1); MHP Contract, Ex. A, Att. 12, sec. 6(B)(7)(a)-(b).) | • P&Ps<br>• Appeal/Expedited Appeal samples<br>• Appeal/Expedited Appeal tracking mechanism/log |

| 6.5 CONTINUATION OF SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.5.1 | The MHP must continue the beneficiary's benefits if all of the following occur:<br>a) The beneficiary files the request for an appeal within 60 calendar days following the date on the adverse benefit determination notice;<br>b) The appeal involves the termination, suspension, or reduction of a previously authorized service;<br>c) The services were ordered by an authorized provider;<br>d) The period covered by the original authorization has not expired; and,<br>e) The beneficiary timely files for continuation of benefits.<br>(42 C.F.R. § 438.420(a)-(b); MHP Contract, Ex. A, Att. 12, sec. 9(B)(1)-(5).) | • P&Ps<br>• Documentation of continued services for beneficiaries pending appeals and/or State Hearings<br>• Documentation of written notice to beneficiaries, if Aid Paid Pending (APP) criteria are met |

| 6.5 CONTINUATION OF SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 6.5.2 | If, at the beneficiary's request, the MHP continues the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the following occurs:<br>a) The beneficiary withdraws the appeal or request for a State Hearing;<br>b) The beneficiary does not request a State Hearing and continuation of benefits within 10 calendar days from the date the MHP sends the notice of adverse appeal resolution (i.e., NAR);<br>c) A State Hearing office issues a hearing decision adverse to the beneficiary.<br>(42 C.F.R. § 438.420(c)(1)-(3); 42 C.F.R. § 438.408(d)(2); MHP Contract, Ex. A, Att. 12, sec. 9(C).) | • P&Ps<br>• Documentation of continued services for beneficiaries pending appeals and/or State Hearings<br>• Documentation of written notice to beneficiaries, if Aid Paid Pending (APP) criteria are met |

# Category 7: Program Integrity

| 7.1 COMPLIANCE PROGRAM | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 7.1.1 | The MHP has a Compliance program designed to detect and prevent fraud, waste and abuse.<br>(42 C.F.R. §§ 438.608(a)(1); 455.1(a)(1); MHP Contract, Ex. A, Att. 13, sec. 3(B).) | • P&Ps<br>• Compliance Plan |
| 7.1.2 | The MHP Compliance program includes:<br>Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(1)(i).) | • P&Ps<br>• Compliance Plan<br>• Standards of conduct template<br>• Sample of completed and signed acknowledgement of standards of conduct |
| 7.1.3 | A system for training and education for the Compliance Officer (CO), the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(1)(iv).) | • P&Ps<br>• Evidence of completed compliance training, training records<br>• Compliance training plan<br>• Compliance training curriculum<br>• Duty statement/job description of Compliance Officer<br>• Compliance Training tracking mechanism (log, training record etc.) |

| 7.1 COMPLIANCE PROGRAM | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 7.1.4 | The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract. (42 C.F.R. § 438.608(a)(1)(vii); MHP Contract, Ex. A, Att. 13, sec. 3(B)(7).) | • P&Ps<br>• Compliance Plan<br>• Compliance monitoring and auditing tool<br>• Compliance Monitoring and auditing results |

| 7.2 FRAUD REPORTING REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 7.2.1 | The MHP, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the MHP for coverage of services and payment of claims under the MHP Contract, shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include prompt reporting to DHCS about the following:<br>1) Any potential fraud, waste, or abuse. (42 C.F.R. § 438.608(a)(7).)<br>2) All overpayments identified or recovered, specifying the overpayments due to potential fraud. (42 C.F.R. § 438.608(a)(2); MHSUDS IN No. 19-034.)<br>3) Information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MHP. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(4).) | • P&Ps<br>• Compliance Plan<br>• Compliance monitoring and auditing tools<br>• Compliance monitoring and auditing results<br>• Evidence of reporting to DHCS<br>• Evidence of tracking of overpayments to providers |

| 7.2 FRAUD REPORTING REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 7.2.2 | If the MHP identifies an issue or receives notification of a complaint concerning an incident of potential fraud, waste or abuse, in addition to notifying DHCS, the MHP shall conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed. (MHP Contract, Ex. A, Att. 13.) | • P&Ps<br>• Compliance Plan<br>• Compliance monitoring and auditing tools<br>• Compliance monitoring and auditing results<br>• Evidence of tracking of overpayments to providers |
| 7.2.3 | The MHP shall implement and maintain written policies for all employees of the MHP, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(6).) | • P&Ps<br>• Compliance Plan<br>• Compliance monitoring and auditing tools<br>• Compliance monitoring and auditing results<br>• Evidence of tracking of overpayments to providers. |
| 7.2.4 | The MHP shall implement and maintain arrangements or procedures that include provision for the MHP's suspension of payments to a network provider for which there is a credible allegation of fraud. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(8).) | • P&Ps<br>• Compliance Plan<br>• Compliance monitoring and auditing tools<br>• Compliance monitoring and auditing results<br>• Evidence of tracking of overpayments to providers |

| 7.3 | SERVICE VERIFICATION REQUIREMENTS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 7.3.1 | The MHP, and/or any subcontractor, to the extent that the subcontractor is delegated responsibility by the MHP for coverage of services and payment of claims under the MHP Contract, implements and maintains arrangements or procedures designed to detect and prevent fraud, waste and abuse that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular basis<br>(42 C.F.R. § 438.608(a)(5); MHP Contract, Ex. A, Att. 13, sec. 5.) | • P&Ps<br>• Tools for verifying services were furnished (service verification letter template etc.)<br>• Evidence of service verification activities (Sample of service verification letter etc.)<br>• Service verification tracking mechanism/log with outcomes |

| 7.4 | DISCLOSURE REQUIREMENTS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 7.4.1 | Disclosures must include:<br>a) The name and address of any person (individual or corporation) with an ownership or control interest in the network provider.<br>b) The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;<br>c) Date of birth and Social Security Number (in the case of an individual);<br>d) Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest);<br>e) Whether the person (individual or corporation) with an ownership or control interest in the MHP's network provider is related to another person with ownership or control interest in the same or any other network provider of the MHP as a spouse, parent, child, or sibling; or | • P&Ps<br>• Provider contracts with reporting requirements<br>• Disclosure monitoring and tracking mechanism/tools/log<br>• Provider/employee disclosure forms<br>• Sample of completed provider/employee disclosure forms<br>• Results of disclosure monitoring activities |

| 7.4 DISCLOSURE REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 7.4.1 cont. | whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care entity has a 5 percent or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;<br>f) The name of any other disclosing entity in which the MHP or subcontracting network provider has an ownership or control interest; and<br>g) The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.<br>h) The MHP shall provide DHCS with all disclosures before entering into a network provider contract with the provider and annually thereafter and upon request from DHCS during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104.<br>(42 C.F.R. § 455.104 (b); MHP Contract, Ex. A, Att. 13, sec. 6 (A)(2)-(3).) | |
| 7.4.2 | The MHP shall submit the following disclosures to DHCS regarding the MHP's management:<br>1. The identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).)<br>2. The identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).) For this purpose, the word "agent" has the meaning described in 42 Code of Federal Regulations part 455.101.<br><br>(MHP Contract, Ex. A, Att. 13, sec. 6(C)(1)(a)-(b). | • P&Ps<br>• Provider contracts with reporting requirements<br>• Disclosure monitoring and tracking mechanism/tools/log<br>• Provider/employee disclosure forms<br>• Sample of completed provider/employee disclosure forms<br>• Results of disclosure monitoring activities |

| 7.5 DATABASE CHECK REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **SUGGESTED DOCUMENTATION** |
| 7.5.1 | The MHP has a process, at the time of hiring/ contracting, to confirm the identity and exclusion status of all providers (employees, network providers, subcontractors, person's with ownership or control interest, managing employee/agent of the MHP). This includes checking the:<br>a) Social Security Administration's Death Master File<br>b) National Plan and Provider Enumeration System (NPPES)<br>c) Office of the Inspector General List of Excluded Providers and Entities(LEIE)<br>d) System of Award Management (SAM)<br>e) Department's Medi-Cal Suspended and Ineligible List (S&I List)<br><br>(MHP Contract, Ex. A, Att. 13; 42 C.F.R. §§ 438.602(b), (d) and 455.436.) | • P&Ps<br>• Reports of database queries from MHP and/or sub-contractors directly checking the database, or utilizing third-party vendors checking the database<br>• Database check tracking mechanism/logs<br>• Contract with vendor providing database check service |
| 7.5.2 | The MHP has a process to confirm monthly that no providers are on the:<br>a) OIG List of Excluded Individuals/Entities (LEIE).<br>b) System of Award Management (SAM) Excluded Parties List System (EPLS).<br>c) DHCS Medi-Cal List of Suspended or Ineligible Providers (S&I List).<br><br>(42 C.F.R. § 455.436.) | • P&Ps<br>• Reports of database queries<br>• Database check tracking mechanism/logs<br>• Contract with vendor providing database check service |
| 7.5.3 | If the MHP finds a party that is excluded, it must promptly notify DHCS. (42 C.F.R. § 438.602(d)).) | • P&Ps<br>• Evidence of corrective action measures<br>• Evidence of notification to DHCS |
| 7.6.3 | The MHP ensures all applicable network providers, including individual rendering providers and Specialty Mental Health facilities, enroll through DHCS' Provider Application and Validation for Enrollment (PAVE) portal (unless the facility is required to enroll via CDPH). (42 U.S.C. § 1396u-2(d)(6); 42 C.F.R. § 438.602; BHIN No. 20-071.) | • P&Ps<br>• Enrollment tracking mechanism<br>• Verification reports<br>• Verification sample of 5 completed applications with submission and enrollment dates |

# Category 8: Chart Review- Non-Hospital Services

| 8.1 MEDICAL NECESSITY AND CRITERIA FOR ACCESS TO SMHS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.1.1 | SMHS provided to a beneficiary must be "medically necessary" or a "medical necessity" as follows:<br>a) Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.<br>b) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code Section 1396d(r)(5) of Title 42 of the United States Code, including all Medicaid-coverable health care services needed to correct and ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are thus covered as EPSDT<br><br>(BHIN 21-073) | • Beneficiary Records |

| 8.1 | MEDICAL NECESSITY AND CRITERIA FOR ACCESS TO SMHS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.1.2 | <u>Criteria for Adult Beneficiaries to Access the SMHS Delivery System</u><br><br>For beneficiaries 21 years of age or older, a county MHP shall provide covered SMHS for beneficiaries who meet **both of the following** criteria, (1) and (2) below:<br><br>1) The beneficiary has **one or both** of the following:<br>a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.<br><br>b. A reasonable probability of significant deterioration in an important area of life functioning.<br><br>**AND**<br><br>2) The beneficiary's condition as described in paragraph (1) is due to **either of the following**:<br>a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.<br>b. A suspected mental disorder that has not yet been diagnosed.<br><br>(BHIN 21-073) | • Beneficiary medical records |

| 8.1 | MEDICAL NECESSITY AND CRITERIA FOR ACCESS TO SMHS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.1.3 | <u>Criteria for Beneficiaries under Age 21 to Access the SMHS Delivery System</u><br><br>For enrolled beneficiaries under 21 years of age, a county MHP shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:<br><br>(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.<br><br>OR<br><br>(2) The beneficiary meets both of the following requirements in a) and b), below:<br><br>a) The beneficiary has at least one of the following:<br><br>i. A significant impairment<br>ii. A reasonable probability of significant deterioration in an important area of life functioning<br>iii. A reasonable probability of not progressing developmentally as appropriate.<br>iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide. | • Beneficiary medical records |

| 8.1 MEDICAL NECESSITY AND CRITERIA FOR ACCESS TO SMHS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.1.3 cont. | **AND**<br><br>b) The beneficiary's condition as described in subparagraph (2) above is due to **one of the following**:<br><br>i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.<br>ii. A suspected mental health disorder that has not yet been diagnosed.<br>iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.<br><br>If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.<br><br>(BHIN 21-073) | |
| 8.1.4 | The Contractor shall provide or arrange and pay for all medically necessary covered SMHS in a sufficient amount, duration, and scope to reasonably achieve the purpose for which the services are furnished.<br>(MHP Contract, Ex. A, Att. 2, Sec. 2(D); 42 CFR 438.210). | • P&Ps<br>• Beneficiary medical records |

| 8.2 ASSESSMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.2.1 | **SURVEY ONLY**<br>The time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.<br><br>(BHIN 22-019) | • Beneficiary medical records |
| 8.2.2 | **SURVEY ONLY**<br>The SMHS assessment shall include the following seven required domains. Providers shall document the domains in the SMHS assessment and keep the assessment in the beneficiary's medical record.<br><br>Domain 1:<br>• Presenting Problem(s)<br>• Current Mental Status<br>• History of Presenting Problem(s)<br>• Beneficiary-Identified Impairment(s)<br><br>Domain 2:<br>• Trauma<br><br>Domain 3:<br>• Behavioral Health History<br>• Comorbidity | • Beneficiary medical records |

| 8.2 ASSESSMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.2.1 cont. | Domain 4:<br>• Medical History<br>• Current Medications<br>• Comorbidity with Behavioral Health<br><br>Domain 5:<br>• Social and Life Circumstances<br>• Culture/Religion/Spirituality<br><br>Domain 6:<br>• Strengths, Risk Behaviors, and Safety Factors<br><br>Domain 7:<br>• Clinical Summary and service recommendations<br>• International Classification of Diseases (ICD) Code<br>• Medical Necessity Determination/Level of Care/Access Criteria<br><br>(BHIN 22-019) | |
| 8.2.2 | **SURVEY ONLY**<br>The assessment ***shall include*** a typed or legibly printed name, signature of the service provider and date of signature.<br>(BHIN 22-019) | • Beneficiary medical records |

| 8.2 ASSESSMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.2.4 | **SURVEY ONLY**<br>The assessment ***shall include*** the provider's determination of medical necessity and recommendation for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.<br>(BHIN 22-019) | • Beneficiary medical records |
| 8.2.5 | **SURVEY ONLY**<br>The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health ***must be completed by*** a provider, operating in his/her scope of practice under California State law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan.<br><br>The MHP may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals. (Cal. Code Regs., tit. 9, § 1840.344; California State Plan, Sec. 3, Att. 3.1-A, Supp. 3, pp. 2m-p; California State Plan Section 3, Att.3.1-B, Supp. 2, pp.15-17)<br><br>(BHIN 22-019) | • Beneficiary medical records |

| 8.3 PROBLEM LIST | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.3.1 | **SURVEY ONLY**<br>The provider(s) responsible for the beneficiary's care shall create and maintain a problem list.<br><br>(BHIN 22-019) | • Beneficiary medical records |
| 8.3.2 | **SURVEY ONLY**<br>The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary.<br><br>(BHIN 22-019) | • Beneficiary medical records |
| 8.3.3 | **SURVEY ONLY**<br>The problem list shall include, but is not limited to, the following:<br>a) Diagnoses identified by a provider acting within their scope of practice, if any.<br>i. Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.<br>b) Problems identified by a provider acting within their scope of practice, if any.<br>c) Problems or illnesses s identified by the beneficiary and/or significant support person, if any.<br>d) The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.<br><br>(BHIN 22-019) | • Beneficiary medical records |

| 8.3 PROBLEM LIST | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.3.4 | **SURVEY ONLY**<br>Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.<br><br>(BHIN 22-019) | • Beneficiary medical records |

| 8.4 TARGETED CASE MANAGEMENT AND INTENSIVE CARE COORDINATION CARE PLANS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.4.1 | **SURVEY ONLY**<br><br>Targeted Case Management (TCM) and Intensive Care Coordination (ICC) care plan Development (and periodic revision) should be based on the information collected through the assessment, that includes the following:<br><br>(i) Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.<br>(ii) Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.<br>(iii) Identifies a course of action to respond to the assessed needs of the eligible individual.<br><br>(BHIN 22-019, 42 CFR, 440.169(d)(2)) | • Beneficiary medical records |

| 8.4 TARGETED CASE MANAGEMENT AND INTENSIVE CARE COORDINATION CARE PLANS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.4.2 | TCM and ICC documentation must address Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, **and including at least one annual monitoring, to help determine whether the following conditions are met:**<br><br>(i) Services are being furnished in accordance with the individual's care plan.<br><br>(ii) Services in the care plan are adequate.<br><br>(iii) There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers when there are changes in the needs or status of the eligible individual.<br><br>(iv) Monitoring of the care plan is conducted on an annual basis.<br><br>(42 CFR, 440.169(d)(4)) | • P&Ps<br>• Beneficiary medical records<br>• MHP's scope of practice policies |

| 8.5 PROGRESS NOTES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.5.1 | **SURVEY ONLY**<br>Providers shall create progress notes for the provision of all SMHS services.<br><br>(BHIN 22-019) | • Beneficiary medical records |
| 8.5.2 | **SURVEY ONLY**<br>Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.<br><br>(BHIN 22-019) | • Beneficiary medical records |
| 8.5.3 | **SURVEY ONLY**<br>Progress notes shall include:<br><br>1. The type of service rendered.<br>2. A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).<br>3. The date that the service was provided to the beneficiary.<br>4. Duration of the service. Including documentation and travel<br>5. Location of the beneficiary at the time of receiving the service.<br>6. A typed or legibly printed name, signature of the service provider and date of signature.<br>7. ICD 10 code.<br>8. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. | • Beneficiary medical records<br>• Sample of Claims |

| 8.5 PROGRESS NOTES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| | 9. Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.<br><br>(BHIN 22-019) | • |
| 8.5.4 | **SURVEY ONLY**<br>Providers shall complete progress notes within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.<br><br>(BHIN 22-019) | • Beneficiary medical records |
| 8.5.5 | **SURVEY ONLY**<br>For services that are billed on a daily basis, such as residential and day treatment services (including therapeutic foster care, day treatment intensive, and day rehabilitation) providers shall complete a Daily Progress Note. Weekly summaries will no longer be required for day rehabilitation and day treatment intensive.<br><br>(BHIN 20-019) | • Beneficiary medical records |

| 8.5 PROGRESS NOTES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.5.6 cont. | **SURVEY ONLY**<br>When a group service is rendered the following requirements shall be met:<br><br>1) A list of participants is required to be documented and maintained by the plan or provider.<br>2) Should more than one provider render a group service, one progress note may be completed for a group session and signed by one provider.<br>3) While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time.<br><br>NOTE: A separate claim for reimbursement must be submitted for each SMHS provided by each practitioner. (BHIN 22-019; CCR, tit. 9, § 1840.314(c); BHIN 20-060R.) | |

| 8.6 TELEHEALTH CONSENT | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.6.1 | **SURVEY ONLY**<br>If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider must document in the patient record the provision of the following information and the patient's verbal or written acknowledgment that the information was received.<br><br>a) The provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary:<br><br>b) An explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in- person, face-to-face visit;<br>c) An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future;<br><br>d) An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the<br><br>e) Potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.<br><br>(BHIN 22-019) | • Beneficiary medical records |

| 8.6 TELEHEALTH CONSENT | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.6.2 | Providers are required to complete service documentation in the patient record in the same manner as in-person visit. The fact that a service was performed by telehealth or telephone must be clearly documented in the chart and must be reflected in the claim, using the appropriate billing code and modifier, as described below.<br><br>The Short Doyle claiming system now accepts telehealth and telephone modifiers in DMC, DMC-ODS and SMHS.<br><br>Use of telehealth and telephone modifiers is mandatory as of November 1, 2021, and encouraged before this date, to allow accurate tracking of telehealth and telephone usage in behavioral health.<br><br>Billing codes must be consistent with the level of care provided. The following codes shall be used in DMC-ODS, DMC and SMHS:<br>• Telehealth (synchronous audio and video) service: GT<br>• Telephone (audio-only) service: SC<br>• Store and forward (e-consult in DMC ODS): GQ<br><br>(BHIN 21-047) | • Beneficiary medical records |

| 8.7 ICC AND IHBS SERVICES FOR CHILDREN AND YOUTH | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.7.1 | The MHP must make individualized determinations of each child's/youth's need for ICC and IHBS, based on the child's/youth's strengths and needs. (Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (3d ed. 2018), p. 9). | • P&Ps<br>• Beneficiary medical records<br>• ICC/IHBS service criteria<br>• List of beneficiaries receiving ICC/IHBS |
| 8.7.2 | The ICC Coordinator and the CFT reassesses the strengths and needs of children and youth, and their families, at least every 90 days, and as needed.<br>(Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (3d ed. 2018), p. 26). | • P&Ps<br>• Beneficiary medical records<br>• ICC/IHBS service criteria<br>• List of beneficiaries receiving ICC/IHBS |
| 8.7.3 | Claims for ICC must use the following:<br>1) Procedure code T1017<br>2) Procedure modifier "HK"<br>3) Mode of service 15<br>4) Service function code 07<br>(Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (3d ed. 2018), p. 30). | • P&Ps<br>• Beneficiary medical records<br>• ICC/IHBS claim lines |
| 8.7.4 | Claims for IHBS must use the following:<br>1) Procedure code H2015<br>2) Procedure modifier "HK"<br>3) Mode of service 15<br>4) Service function code 57<br>(Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (3d ed. 2018), pp. 33-34). | • P&Ps<br>• Beneficiary medical records<br>• ICC/IHBS claim lines |

| 8.7 ICC AND IHBS SERVICES FOR CHILDREN AND YOUTH | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.7.5 | Each participating provider in a CFT meeting may claim for the time they have contributed to the CFT meeting, up to the length of the meeting, plus documentation and travel time, in accordance with CCR, tit. 9, § 1840.316(b)(3).<br>(Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (3d ed. 2018), p. 21). | • P&Ps<br>• Beneficiary medical records<br>• ICC/IHBS claim lines |

| 8.8 LINGUISTICALLY COMPETENT SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.8.1 | There is evidence that mental health interpreter services are offered and provided, when applicable. (MHP Contract, Ex. A, Att. 11, Sec. 3(E)). | • P&Ps<br>• Sample of beneficiary medical records |
| 8.8.2 | If the needs for language assistance is identified in the assessment, there is documentation of linking beneficiaries to culture-specific and/or linguistic services as described in the MHP's CCPR. (DMH Information Notice 10-17, Enclosure 1; See 9 CCR 1810.410; 42 CFR 438.10). | • P&Ps<br>• Beneficiary medical records |
| 8.8.3 | The MHP shall make its written materials that are critical to obtaining services available to beneficiaries in prevalent non-English languages. (MHP Contract, Ex. A, Att. 11, Sec. 3(C); 42 C.F.R. § 438.10(d)). | • P&Ps<br>• Sample of beneficiary medical records<br>(This applies to the identified threshold languages of the specific county.) |

| 8.8 LINGUISTICALLY COMPETENT SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.8.4 | When applicable, treatment specific information was provided to beneficiaries in an alternative format (e.g., braille, audio, large print, etc.). (MHP Contract, Ex. A, Att. 11, Secs. 1(A), 3(B) CCR, tit. 9, §§ 1810.410(e)(2); 3200.210). | • P&Ps<br>• Beneficiary medical records |

| 8.9 DAY TREATMENT INTENSIVE AND DAY REHABILITATION SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.9.1 | Day Treatment Intensive (DTI) and Day Rehabilitation (DR) programs include all the following required service components:<br><br>A. Therapeutic milieu<br>B. Process Groups (Day rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.)<br>C. Skill-building Groups and,<br>D. Adjunctive Therapies<br>E. Additionally, Day Treatment Intensive programs also require Psychotherapy<br><br>(MHP Contract, Ex. A, Att. 2, Sec. 3(C)). | • P&Ps<br>• Program Description<br>• Weekly Schedule<br>• Beneficiary medical records |
| 8.9.2 | For both DTI and DR, there is a Written Program Description that describes the specific activities of each service and reflects each of the required components described in the MHP Contract. (MHP Contract, Ex. A, Att. 2, Sec. 3(I)). | • P&Ps<br>• Program Description<br>• Beneficiary medical records |

| 8.9 DAY TREATMENT INTENSIVE AND DAY REHABILITATION SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.9.3 | For both DTI and DR, there is an established Mental Health Crisis Protocol, which may be part of the written program description, for responding to beneficiaries experiencing a mental health crisis.<br><br>(1) The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other SMHS necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day treatment intensive or day rehabilitation program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service.<br><br>(MHP Contract, Ex. A, Att. 2, Sec. 3(D)(2); DMH IN No. 02-06, encl. 1, p. 3). | • P&Ps<br>• Program Description<br>• Mental Health Crisis Protocol<br>• Beneficiary medical records |
| 8.9.4 | For both DTI and DR, the Contractor shall ensure that a Weekly Detailed Schedule is available to beneficiaries and as appropriate to their families, caregivers or significant support persons and identifies when and where the service components of the program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their services. (MHP Contract, Ex. A, Att. 2, Sec. 3(D)(3); DMH IN No. 02-06, encl. 1, p. 3). | • P&Ps<br>• Program Description<br>• Weekly Schedule<br>• Beneficiary medical records |

| 8.9 DAY TREATMENT INTENSIVE AND DAY REHABILITATION SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.9.5 | The MHP shall ensure that the provider receives Medi-Cal reimbursement only if the beneficiary is present for at least 50 percent of scheduled hours of operation for that day.<br><br>In cases where absences are frequent, it is the responsibility of the MHP to ensure that the provider re-evaluates the beneficiary's need for the day rehabilitation or day treatment intensive program and takes appropriate action.<br><br>(MHP Contract, Ex. A, Att. 2, Sec. 3(F).). | • P&Ps<br>• Documented evidence of beneficiary(ies) being present for at least 50% of scheduled hours of operation for each day<br>• Program Description<br>• Beneficiary medical records |
| 8.9.6 | When claiming for the continuous hours of operation for Day Treatment Intensive and Day Rehabilitation, the program provides:<br>1. For Half Day: Face-to-face services a minimum of three hours each program day.<br>2. For Full Day: Face-to-face services for more than 4 hours per day.<br>(MHP Contract, Ex. A, Att. 2, Sec. 3(J); CCR, tit. 9, § 1840.318). | • P&Ps<br>• Beneficiary medical records |
| | **DAY TREATMENT INTENSIVE STAFFING**<br>DTI includes the following staffing (MHP Contract, Ex. A, Att. 2, Sec. 3(E); CCR, tit. 9, § 1840.350). | |

| 8.9 DAY TREATMENT INTENSIVE AND DAY REHABILITATION SERVICES | | |
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| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.9.7 | For DTI, at a minimum there must be an average ration of at least one person from the following list to 8 beneficiaries or other clients in attendance during the period the program is open:<br>(1) Physician<br>(2) Psychologist or related registered/waivered professional<br>(3) LCSW or related registered/waivered professional.<br>(4) MFT or related registered/waivered professional.<br>(5) Registered Nurses<br>(6) Licensed Vocational Nurses<br>(7) Psychiatric Technicians<br>(8) Occupational Therapists<br>(9) Mental Health Rehabilitation Specialists (defined in title 9, section 630)<br>(10) Persons providing services who do not participate in the entire Day Rehab session, whether full or half-day, shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time they participated in the session. | • P&Ps<br>• Weekly Schedule<br>• Staffing Schedules<br>• Beneficiary medical records |
| 8.9.8 | For Day Treatment Intensive, staff shall include at least one staff person whose scope of practice includes psychotherapy. | • P&Ps<br>• Beneficiary medical records |
| 8.9.9 | The MHP shall ensure there is a clear audit trail of the number and identity of the persons who provide Day Treatment Intensive services and function in other capacities. | • P&Ps<br>• Beneficiary medical records |
| 8.9.10 | If there are more than twelve clients in the Day Treatment Intensive program, staffing shall include at least one (1) staff from two of the groups in the above list in requirement 8.9.7. | • P&Ps<br>• Beneficiary medical records |

| 8.9 DAY TREATMENT INTENSIVE AND DAY REHABILITATION SERVICES | | |
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| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| | **DAY REHABILITATION STAFFING**<br>DR includes the following staffing (MHP Contract, Ex. A, Att. 2, Sec. 3(E); CCR, tit. 9, § 1840.352). | |
| 8.9.11 | For DR, at a minimum there must be an average ratio of at least one person from the following list to 10 beneficiaries or other clients in attendance during the period the program is open:<br>(1) Physician<br>(2) Psychologist or related registered/waivered professional<br>(3) LCSW or related registered/waivered professional<br>(4) MFT or related registered/waivered professional<br>(5) Registered Nurses<br>(6) Licensed Vocational Nurses<br>(7) Psychiatric Technicians<br>(8) Occupational Therapists<br>(9) Mental Health Rehabilitation Specialists (defined in title 9, section 630)<br>(10) Persons providing services who do not participate in the entire Day Rehab session, whether full or half-day, shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time they participated in the session. | • P&Ps<br>• Weekly Schedule<br>• Staffing Schedules<br>• Beneficiary medical records |
| 8.9.12 | The MHP shall ensure there is a clear audit trail of the number and identity of the persons who provide Day Rehabilitation services and function in other capacities. | • P&Ps<br>• Beneficiary medical records |
| 8.9.13 | If there are more than twelve clients in the Day Rehabilitation program, staffing shall include at least two (2) staff from the above list. | • P&Ps<br>• Beneficiary medical records |

| 8.9 DAY TREATMENT INTENSIVE AND DAY REHABILITATION SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| | **DAY TREATMENT INTENSIVE DOCUMENTATION REQUIREMENTS:** | |
| 8.9.14 | **SURVEY ONLY**<br>DTI documentation requirements include:<br>1. Daily Progress Notes on activities attended.<br>2. Monthly documentation of one contact with family, care-giver, or significant support person identified by an adult beneficiary or one contact per month with the legally responsible adult for a beneficiary who is a minor.<br>A. This contact is face-to face or by an alternative method such as email, telephone, etc.<br>B. This contact focuses on the role of the support person in supporting the beneficiary's community reintegration.<br>C. This contact occurs outside the hours of operation and outside the therapeutic program.<br>(MHP Contract, Ex. A, Att. 2, Sec. 3(H); BHIN 22-019). | • P&Ps<br>• Beneficiary medical records |
| | **DAY REHABILITATION DOCUMENTATION REQUIREMENTS:** | |
| 8.9.15 | **SURVEY ONLY**<br><br>DR documentation requirements include:<br>A. Daily Progress Note<br>B. Monthly documentation of one contact with family, care-giver, or significant support person identified by an adult beneficiary or one contact per month with the legally responsible adult for a beneficiary who is a minor. | • P&Ps<br>• Beneficiary medical records |

| 8.9 DAY TREATMENT INTENSIVE AND DAY REHABILITATION SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 8.9.15 cont. | C. This contact is face-to face or by an alternative method such as email, telephone, etc.<br>D. This contact focuses on the role of the support person in supporting the beneficiary's community reintegration.<br>E. This contact occurs outside the hours of operation and outside the therapeutic program.<br><br>(MHP Contract, Ex. A, Attachments 2, Sec. 3(H); BHIN 22-019). | • |

# Category 9: Chart Review- SD/MC Hospital Services

| 9.1 MEDICAL NECESSITY | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 9.1.1 | SMHS provided to a beneficiary must be "medically necessary" or a "medical necessity" as follows:<br><br>• Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.<br>• For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code Section 1396d(r)(5) of Title 42 of the United States Code, including all Medicaid-coverable health care services needed to correct and ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are thus covered as EPSDT.<br><br>(BHIN 22-017) | • P&Ps<br>• Beneficiary medical records |

| 9.1 MEDICAL NECESSITY | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 9.1.2 | The beneficiary has a current ICD/DSM diagnosis which is included in CCR, title 9, sections 1820.205(a)(1)(A) through 1820.205(a)(1)(R), or in the current BHIN annual ICD-10 diagnosis code update.<br>(CCR, tit. 9, § 1820.205(a)(1).) | • P&Ps<br>• Beneficiary medical records |
| 9.1.3 | 1. Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode must be considered to have met this criterion.<br><br>(CCR, tit. 9, § 1820.205(a)(2)(A); 42 C.F.R. § 456.160). | • P&Ps<br>• Beneficiary medical records |
| 9.1.4 | 2. Requires psychiatric inpatient hospital services, as the result of a mental disorder or emotional disturbance, due to indications in either (a) or (b) below:<br><br>a) Has symptoms or behaviors due to a mental disorder or emotional disturbance that (one of the following):<br>A. Represents a current danger to self or others, or significant property destruction.<br>B. Prevents the beneficiary from providing for, or utilizing food, clothing or shelter.<br>C. Presents a severe risk to the beneficiary's physical health.<br>D. Represents a recent, significant deterioration in ability to function. | • P&Ps<br>• Beneficiary medical records |

| 9.2 CONTINUED STAY SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 9.1.4 cont. | b) Requires admission for one of the following:<br>A. Further psychiatric evaluation.<br>B. Medication treatment.<br>C. Other treatment which could reasonably be provided only if the beneficiary were hospitalized.<br><br>(CCR, tit. 9, § 1820.205(a)(2)(B)(1)-(2); 42 C.F.R. § 456.170). | |
| 9.2.1 | The beneficiary's continued stay services in a psychiatric inpatient hospital meets one of the following reimbursement criteria:<br><br>(1) Continued presence of indications which meet the medical necessity criteria for psychiatric inpatient hospital services. (CCR, tit. 9, § 1820.205(b)(1)).<br>(2) Serious adverse reaction to medication, procedures, or therapies requiring continued hospitalization. (CCR, tit. 9, § 1820.205(b)(2)).<br>(3) Presence of new indications which meet medical necessity criteria for psychiatric inpatient hospital services. (CCR, tit. 9, § 1820.205(b)(3)).<br>(4) Need for continued medical evaluation or treatment that could only have been provided if the beneficiary remained in a psychiatric inpatient hospital. (CCR, tit. 9, § 1820.205(b)(4)). | • P&Ps<br>• Beneficiary medical records |

| 9.3 ADMINISTRATIVE DAY SERVICES | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| | If payment has been authorized for administrative day services, the following requirements are met: | |
| 9.3.1 | During the hospital stay, the beneficiary previously met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services. (CCR, tit. 9, § 1820.220(l)(5)(A)). | • P&Ps<br>• Beneficiary medical records |
| 9.3.2 | There is no appropriate, non-acute treatment facility within a reasonable geographic area. (CCR, tit. 9, § 1820.220(l)(5)(B)). | • P&Ps<br>• Beneficiary medical records |
| 9.3.3 | The hospital documents contacts with a minimum of five (5) appropriate, non-acute treatment facilities per week subject to the following requirement:<br><br>1. Point of Authorization staff may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.<br>2. The lack of placement options at appropriate, non-acute residential treatment facilities and the contacts made at appropriate facilities must be documented to include, but not be limited to:<br>a) The status of the placement option.<br>b) Date of the contact.<br>c) Signature of the person making the contact.<br>(CCR, tit. 9, § 1820.220(l)(5)(B)(1) and (2)) | • P&Ps<br>• Beneficiary medical records |

| 9.4 BENEFICIARY INFORMATION REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 9.4.1 | Oral interpretation, in all languages, and auxiliary aids, such as TTY/TDY and American Sign Language (ASL), shall be made available, free of cost, to beneficiaries. (MHP Contract, Ex. A, Att. 11, Sec. 3(E); 42 C.F.R. § 438.10(d)(2), (4)-(5)). | • P&Ps<br>• Beneficiary medical records |
| 9.4.2 | When applicable, there is documentation in the beneficiary's medical record that services were provided, or offered, in the beneficiary's preferred language. (CCR, tit. 9, § 1810.410). | • P&Ps<br>• Beneficiary medical records |
| 9.4.3 | All written materials for beneficiaries must be made available in alternative formats and through the provision of auxiliary aids and services, in an appropriate manner that takes into consideration the special needs of beneficiaries with disabilities or limited English proficiency. (MHP Contract, Ex. A, Att. 11, Sec. 1(A); 42 C.F.R. § 438.10(d)(6)). | • P&Ps<br>• Beneficiary medical records |
| 9.4.4 | A beneficiary has the right to receive information in accordance with the language and format requirements in 42 C.F.R. § 438.10(d). (MHP Contract, Ex. A, Att. 11, Sec. 7(B)(1); 42 C.F.R. § 438.100(b)(2)(i)). | • P&Ps<br>• Beneficiary medical records |
| 9.4.5 | A beneficiary has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand. (MHP Contract, Ex. A, Att. 11, Sec. 7(B)(3); 42 C.F.R. § 438.100(b)(2)(iii)). | • P&Ps<br>• Beneficiary medical records |
| 9.4.6 | The MHP documents in the individual's medical record should document whether or not the beneficiary has executed an advance directive. (42 C.F.R § 422.128(b)(1)(ii)(E)). | • P&Ps<br>• Beneficiary medical records |

| 9.5 | SCREENING, REFERRAL AND COORDINATION REQUIREMENTS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 9.5.1 | Services are coordinated between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. (MHP Contract, Ex. A, Att. 10, Sec. 1(A)(2); 42 C.F.R. § 438.208(b)(2)). | • P&Ps<br>• Beneficiary medical records |
| 9.5.2 | The record documentation in the beneficiary's chart reflects staff efforts to provide screening, referral, and coordination with other necessary services including, but not limited to, substance abuse, educational, health, housing, vocational rehabilitation and Regional Center services. (CCR, tit. 9, § 1810.310(a)(2)(A)). | • P&Ps<br>• Beneficiary medical records |

| 9.6 | SCOPE OF PRACTICE REQUIREMENTS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 9.6.1 | The MHP shall only use licensed, registered, or waivered providers acting within their scope of practice for services that require a license, waiver, or registration. (Cal. Code Regs., tit. 9, § 1840.314(d).)(MHP Contract, Ex. A, Att. 8, Sec. 7(J)). | • P&Ps<br>• Beneficiary medical records |

| 9.7 | WRITTEN PLAN OF CARE REQUIREMENTS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 9.7.1 | Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each applicant or beneficiary. (42 C.F.R. § 456.180(a) and (c)) | • P&Ps<br>• Beneficiary medical record |
| | The beneficiary has a written plan of care that includes the following elements: | |
| 9.7.2 | Diagnoses, symptoms, complaints, and complications indicating the need for admission. (42 C.F.R. § 456.180(b)(1)). | • P&Ps<br>• Beneficiary medical record |
| 9.7.3 | A description of the functional level of the beneficiary. (42 C.F.R. § 456.180(b)(2)). | • P&Ps<br>• Beneficiary medical records |
| 9.7.4 | Specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments resulting from the qualifying mental health diagnosis/diagnoses. (42 C.F.R. § 456.180(b)(3)). | • P&Ps<br>• Beneficiary medical records |
| 9.7.5 | Any orders for:<br><br>a) Medications<br>b) Treatments<br>c) Restorative and rehabilitative services<br>d) Activities<br>e) Therapies<br>f) Social services<br>g) Diet<br>h) Special procedures recommended for the health and safety of the beneficiary.<br><br>(42 C.F.R. § 456.180(b)(4)). | • P&Ps<br>• Beneficiary medical records |

| 9.7 WRITTEN PLAN OF CARE REQUIREMENTS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 9.7.6 | Plans for continuing care, including review and modification to the plan of care. (42 C.F.R. § 456.180(b)(5)). | • P&Ps<br>• Beneficiary medical records |
| 9.7.7 | Plans for discharge. (42 C.F.R. § 456.180(b)(6)). | • P&Ps<br>• Beneficiary medical records |
| 9.7.8 | Documentation of the physician's establishment of the plan. (42 C.F.R. § 456.180(a)). | • P&Ps<br>• Beneficiary medical records |
| 9.7.9 | The attending or staff physician and other personnel involved in the beneficiary's care must review each plan of care at least every 90 days. (C.F.R. § 456.180(c)) | • P&Ps<br>• Beneficiary medical records |

# Category 10: Utilization Review- SD/MC Hospital Services

| 10.1 UTILIZATION REVIEW PLAN | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| | The SD/MC Hospital has a Utilization Review (UR) Plan that:<br>(CCR, tit. 9, § 1820.230; 42 C.F.R. Part 456, subpart D). | |
| 10.1.1 | Provides for a Utilization Review Committee (URC) to perform UR. | • P&Ps<br>• UR Plan<br>• URC Minutes |
| 10.1.2 | Describes the organization, composition, and functions of the committee. | • P&Ps<br>• UR Plan<br>• URC Minutes |
| 10.1.3 | Specifies the frequency of the committee meetings. | • P&Ps<br>• UR Plan<br>• URC Minutes |
| 10.1.4 | The UR plan must provide that each beneficiary's record includes at least the following:<br>a) Identification of the recipient<br>b) The name of the recipient's physician<br>c) The date of admission<br>d) The beneficiary plan of care<br>e) Initial and subsequent continued stay review dates<br>f) Reasons and plan for continued stay (if the attending physician believes continued stay is necessary).<br>g) Other supporting material that the committee believes appropriate to be included in the record.<br>(42 C.F.R. §§ 456.211-213; 456.180; 456.233; 456.234). | • P&Ps<br>• UR Plan |

| 10.1 UTILIZATION REVIEW PLAN | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| | The UR plan includes the following review criteria for continued stay in the psychiatric hospital: | |
| 10.1.5 | Determination of need for continued stay. (42 C.F.R. § 456.231). | • P&Ps<br>• UR Plan |
| 10.1.6 | Evaluation criteria for continued stay. (42 C.F.R. § 456.232). | • P&Ps<br>• UR Plan |
| 10.1.7 | Initial continued stay review date. (42 C.F.R. § 456.233). | • P&Ps<br>• UR Plan |
| 10.1.8 | Subsequent continued stay review dates. (42 C.F.R. § 456.234). | • P&Ps<br>• UR Plan |
| 10.1.9 | Description of methods and criteria for continued stay review dates; length of stay modification. (42 C.F.R. § 456.235). | • P&Ps<br>• UR Plan |
| 10.1.10 | Continued stay review process. (42 C.F.R. § 456.236). | • P&Ps<br>• UR Plan |
| 10.1.11 | Notification of adverse decisions. (42 C.F.R. § 456.237). | • P&Ps<br>• UR Plan |
| 10.1.12 | The UR plan describes:<br>a) The types of records that are kept by the committee and,<br>b) The type and frequency of committee reports and arrangements for their distribution to appropriate individuals.<br>(42 C.F.R. § 456.212). | • P&Ps<br>• UR Plan |

| 10.1 | UTILIZATION REVIEW PLAN | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 10.1.13 | The UR plan must provide that the identities of individual beneficiaries in all UR records and reports are kept confidential. (42 C.F.R. § 456.213). | • P&Ps<br>• UR Plan |

| 10.2 | MEDICAL CARE EVALUATIONS | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| | Regarding Medical Care Evaluations (MCEs) or equivalent studies, the UR plan contains the following: | |
| 10.2.1 | A description of the methods that the URC uses to select and conduct MCE or equivalent studies. (42 C.F.R. §§ 456.241, 456.242(b)(1)). | • P&Ps<br>• UR Plan<br>• MCEs or equivalent studies for each year |
| 10.2.2 | Documentation of the results of the MCE or equivalent studies that show how the results have been used to make changes to improve the quality of care and promote the more effective and efficient use of facilities and services. (42 C.F.R. § 456.242(b)(2)). | • P&Ps<br>• Current and past MCE or equivalent studies for two years |
| 10.2.3 | Documentation that the MCE or equivalent studies have been analyzed. (42 C.F.R. § 456.242(b)(3)). | • P&Ps<br>• Current and past MCE or equivalent studies for two years |
| 10.2.4 | Documentation that actions have been taken to correct or investigate any deficiencies or problems in the review process and recommends more effective and efficient hospital care procedures. (42 C.F.R. § 456.242(b)(4)). | • P&Ps<br>• Current and past MCE or equivalent studies for two years |

| 10.2 MEDICAL CARE EVALUATIONS | | |
|---|---|---|
| **NUMBER** | **REQUIREMENT** | **DOCUMENTATION TO REVIEW** |
| 10.2.5 | The contents of the MCE or equivalent studies meet federal requirements. (42 C.F.R. § 456.243). | • P&Ps<br>• Current and past MCE or equivalent studies for two years |
| 10.2.6 | At least one MCE or equivalent study has been completed each calendar year. (42 C.F.R. § 456.245). | • P&Ps<br>• Current and past MCE or equivalent studies for two years |
| 10.2.7 | An MCE or equivalent study is in progress at all times. (42 C.F.R. § 456.245). | • P&Ps<br>• Current and past MCE or equivalent studies for two years |