CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS DIVISION
MEDICAL REVIEW BRANCH
BEHAVIORAL HEALTH COMPLIANCE SECTION

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

FISCAL YEAR (FY) 2019-2020

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

In accordance with Welfare and Institutions Code (WIC) Section 5614 this serves to notify the County Mental Health Plan (MHP) pursuant to California Code of Regulations (CCR), Title 9, Chapter 11, Sections 1810.325, 1810.380(b), 1810.385, and WIC Section 14712(e), that if the Department determines that an MHP is out of compliance with State or Federal laws and regulations or the terms of the contract between the MHP and the Department, the Department may take any or all of the following actions:

(1) Require that the MHP develop a plan of correction. The plan of correction 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 POC determined not to be effective, the MHP should propose an alternate corrective action plan to DHCS.
   e. Description of corrective actions required of the MHP's contracted providers to address findings.

(2) Withhold all or a portion of payments due to the MHP from the Department.

(3) Impose civil penalties pursuant to Section 1810.385. See also, MHSUDS Information Notice (IN) No. 18-024

(4) Terminate the contract with the MHP pursuant to Section 1810.323.

(5) Take other actions deemed necessary to encourage and ensure contract and regulatory compliance.

If the Department determines that an action should be taken pursuant to Subsection (b), the Department shall provide the MHP with a written Notice of Noncompliance. The Notice of Noncompliance shall include:

(1) A description of the violation

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

(3) A description of any and all proposed actions by the Department under this Section or Sections 1810.385 or 1810.323, and any related appeal rights.

The MHP may appeal, in writing:

1. A proposed contract termination to the Department within 15 working days after the date of receipt of the notice of termination, setting forth relevant facts and arguments. The Department must grant or deny the appeal within 30 calendar days after receipt of the appeal. In granting an appeal, the Department may take another action available under section 1810.380(b). The Department's election to take another action must not be appealable to the Department. Except for terminations pursuant to section 1810.325(c), the Department must suspend the termination date until the Department has acted on the MHP's appeal.
2. A Notice of Non-Compliance to the Department within 15 working days after the date of receipt of the notice of termination, setting forth relevant facts and arguments. The Department must grant or deny the appeal in whole or in part within 30 calendar days after receipt of the appeal. The Department must suspend any proposed action until the Department has acted on the MHP's appeal.

LIST OF ABBREVIATIONS

24/7	24 HOURS A DAY/SEVEN DAYS A WEEK	MOE	MAINTENANCE OF EFFORT
APP	AID PAID PENDING	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
C.F.R.	CODE OF FEDERAL REGULATIONS	OIG LEIE	OFFICE OF INSPECTOR GENERAL'S LIST OF EXCLUDED INDIVIDUALS/ENTITIES
CMS	CENTERS FOR MEDICARE AND MEDICAID SERVICES	P	PARTIAL COMPLIANCE
CPPP	COMMUNITY PROGRAM PLANNING PROCESS	P&Ps	POLICIES AND PROCEDURES
DHCS	DEPARTMENT OF HEALTH CARE SERVICES	PCP	PRIMARY CARE PHYSICIAN
DMH	[FORMER] DEPARTMENT OF MENTAL HEALTH (STATE)	PHI	PROTECTED HEALTH INFORMATION
EPSDT	EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT	PIP	PERFORMANCE IMPROVEMENT PROJECTS
EPLS/SAM	EXCLUDED PARTIES LIST SYSTEM/SYSTEM OF AWARD MANAGEMENT	PLW	PROFESSIONAL LICENSING WAIVER
FY	FISCAL YEAR	POA	POINT OF AUTHORIZATION
IMD	INSTITUTION FOR MENTAL DISEASES	PSC	PERSONAL SERVICES COORDINATOR
IN	INFORMATION NOTICE	QAPI	QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
ITWS	INFORMATION TECHNOLOGY WEB SERVICES	QIC	QUALITY IMPROVEMENT COMMITTEE
LEP	LIMITED ENGLISH PROFICIENCY	RCL	RATE CLASSIFICATION LEVEL
LPHA	LICENSED PRACTITIONER OF THE HEALING ARTS	SD/MC	SHORT-DOYLE/MEDI-CAL
LPT	LICENSED PSYCHIATRIC TECHNICIAN	SMHS	SPECIALTY MENTAL HEALTH SERVICES
LVN	LICENSED VOCATIONAL NURSE	SNF	SKILLED NURSING FACILITY
M/C	MEDI-CAL	STP	SPECIALIZED TREATMENT PROGRAM
MCE	MEDICAL CARE EVALUATION	TAR	TREATMENT AUTHORIZATION REQUEST
MCP	MEDI-CAL MANAGED CARE PLAN	TBS	THERAPEUTIC BEHAVIORAL SERVICES
MHP	MENTAL HEALTH PLAN	TDD/TTY	TELECOMMUNICATION DEVICE FOR THE DEAF/ TEXT TELEPHONE/TELETYPE
MHRC	MENTAL HEALTH REHABILITATION CENTER	UM/UR	UTILIZATION MANAGEMENT/ UTILIZATION REVIEW
MHS	MENTAL HEALTH SERVICES	WIC	WELFARE AND INSTITUTIONS CODE
MHSA	MENTAL HEALTH SERVICES ACT	Y	YES – IN-COMPLIANCE

COUNTY MENTAL HEALTH PLAN ATTESTATION

1.	*The MHP must provide the DHCS issued Medi-Cal Services for Children and Young Adults: Early & Periodic Screening, Diagnostic & Treatment (EPSDT) brochure, which includes information about accessing Therapeutic Behavioral Services (TBS), to Medi-Cal (MC) beneficiaries under 21 years of age and their representative in the following circumstances: at the time of admission to a Skilled Nursing Facility (SNF) with a Specialized Treatment Program (STP) for the mentally disordered; at the time of admission to a Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution for Mental Diseases; at the time of placement in a Rate Classification Level (RCL) 13-14 foster care group home or Short Term Residential Therapeutic Program; and at the time of placement in an RCL 12 foster care group home when the MHP is involved in the placement. (CCR, title 9, § 1810.310 (a)(1); DMH Letter No. 01-07, DMH Letter No. 04-04; DMH Letter No. 04-11; DMH IN No. 08-38; MHP Contract)*
2.	*The MHP shall inform the Department whether it has been accredited by a private independent accrediting entity. (42 C.F.R. 438.332(a).) If the MHP has received accreditation by a private independent accrediting entity, the Contractor shall authorize the private independent accrediting entity to provide the Department a copy of its most recent accreditation review, including:* *1. Its accreditation status, survey type, and level (as applicable);* *2. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and* *3. The expiration date of the accreditation. (42 C.F.R. § 438.332(b).)*
3.	*The MHP shall comply with the conflict of interest safeguards described in 42 Code of Federal Regulations part 438.58 and the prohibitions described in section 1902(a)(4)(C) of the Act. (42 C.F.R. § 438.3(f)(2).)*
4.	*The MHP's officers and employees shall not have a financial interest in this Contract or a subcontract of this Contract made by them in their official capacity, or by any body or board of which they are members unless the interest is remote. (Gov. Code §§ 1090, 1091; 42 C.F.R. § 438.3(f)(2).)*
5.	*The MHP shall not utilize in the performance of this Contract any State officer or employee in the State civil service or other appointed State official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment. (Pub. Con. Code § 10410; 42 C.F.R. § 438.3(f)(2).) The MHP shall submit documentation to the Department of employees (current and former State employees) who may present a conflict of interest. (MHP Contract, Ex. A, Att. 1)*

COUNTY MENTAL HEALTH PLAN ATTESTATION

6.	*Federal Financial Participation is not available for any amount furnished to an excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the Department failed to suspend payments during an investigation of a credible allegation of fraud. (42 U.S.C. section 1396b(i)(2).)*
7.	*The MHP or an affiliate, vendor, contractor, or subcontractor of the Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract, except to collect other health insurance coverage, share of cost, and co-payments. (CCR, tit. 9, § 1810.365 (a).)*
8.	*The MHP must ensure that it contracts with disproportionate share and traditional hospitals when the hospital meets selection criteria unless the MHP has obtained an exemption. CCR, title 9, chapter 11, section 1810.430(a)(b) and (c).*
9.	*The MHP must ensure that the Fee-for-Service/Medi-Cal contract hospital rates negotiated by the MHP are submitted annually. CCR, title 9, chapter 11, section 1810.375(c), and WIC, section 5614 (b)(4).*
10.	*The County must submit Client and Service Information (CSI) System data, including but not limited to, client demographics and descriptions of services provided to each client. The CSI data shall be submitted no later than 60 days after the end of the month in which the services were provided. CCR, title 9, chapter 14, section 3530.10.*
11.	*The MHP must deposit its local matching funds per the schedule developed by the Department. If the county elects not to apply Maintenance of Effort funds, the MHP must be in compliance with WIC, section 17608.05(c) prohibiting the county from using the loss of these funds for realignment purposes. WIC, Section 17608.05*
12.	*The MHP may not decrease the proportion of its funding expended for children's services below the proportion expended in the 1983-1984 fiscal year unless a determination has been made by the governing body in a noticed public hearing that the need for new or expanded services to persons under age 18 has significantly decreased. WIC, Section 5704.5*
13.	*The MHP must allocate (for services to persons under age 18) 50% of any new funding received for new or expanded mental health programs until the amount expended for mental health services to persons under age 18 equals not less than 25% of the county's gross budget for mental health or not less than the percentage of persons under age 18 in the total county population, whichever percentage is less. WIC, Section 5704.6*

SECTION A **NETWORK ADEQUACY AND AVAILABILITY OF SERVICES**

	CRITERIA	FINDING Met/ Unmet		INSTRUCTIONS TO REVIEWERS
I.	***Availability of Specialty Mental Health Services***			
A.	The MHP shall provide, or arrange and pay for, the following medically necessary covered Specialty Mental Health Services (SMHS) to beneficiaries: • Mental health services; • Medication support services; • Day treatment intensive; • Day rehabilitation; • Crisis intervention; • Crisis stabilization; • Adult residential treatment services; • Crisis residential treatment services; • Psychiatric health facility services; • Intensive Care Coordination (for beneficiaries under the age of 21); • Intensive Home Based Services (for beneficiaries under the age of 21); • Therapeutic Behavioral Services (for beneficiaries under the age of 21); • Therapeutic Foster Care (for beneficiaries under the age of 21); • Children's crisis residential programs; • Psychiatric Inpatient Hospital Services; and, • Targeted Case Management. (MHP Contract, Ex. A, Att. 2)			**SUGGESTED DOCUMENTATION:** • Policies and Procedures #_____ • MHP Implementation Plan • Program Descriptions • Provider subcontracts • Performance & Outcomes Systems (POS) Data Reports • Cultural Competence Plan • Other evidence deemed appropriate by review team **GUIDANCE:** • Review the relevant policies and procedures. • Review program/services descriptions. • Review the county specific POS data report. • Review the MHP's service maps and data indicating location of MHP's services. • Children's crisis residential programs for beneficiaries under the age of 18; and between the ages of 18 and 21 as developmentally/clinically appropriate.

SECTION A NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	*The MHP shall offer an appropriate range of SMHS that is adequate for the number of beneficiaries in the county. (42 C.F.R. § 438.207(b)(1).)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Network Adequacy Certification Tool ☐ MHP Implementation Plan ☐ Medi-Cal Eligibility and Utilization Data Analysis Reports ☐ Capacity Data Reports ☐ MHP Service Map ☐ Performance Outcomes System data ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP reviews capacity of its service providers for all service types. • Review data and documentation that services and programs at all levels have the capacity to provide culturally competent services.

SECTION A NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	The MHP must make SMHS available 24 hours a day, 7 days a week, when medically necessary. (42 C.F.R. § 438.206(c)(1)(iii).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Program description for 24/7 services available to beneficiaries ☐ Program descriptions for pre-crisis and crisis services (e.g. mobile crisis response, crisis stabilization, crisis residential, etc.) ☐ Provider contracts ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • This requirement applies to the MHP's network of providers; not each individual provider. • Review and collect data and documentation describing the provision of pre-crisis and crisis services. • The focus of pre-crisis services is to offer ideas and strategies to improve the person's situation, and help access what is needed to avoid crisis. • The focus of crisis services is stabilization and crisis resolution, assessment of precipitating and attending factors, and recommendations for meeting identified needs. • Ask the MHP about its efforts to reduce inappropriate and/or over-utilization of higher level care/placements (e.g., crisis stabilization, crisis residential, inpatient acute psychiatric hospitalization) and emergency services (i.e., emergency departments, ambulance, EMTs, etc.) by its beneficiaries.

SECTION A NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
D.	*The MHP shall implement mechanisms to assess the capacity of service delivery for its beneficiaries. This includes monitoring the number, type, and geographic distribution of mental health services within the MHP's delivery system. (MHP Contract, Ex. A, Att. 8; 42 C.F.R. § 438.207(b)(2).)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Assessment reports ☐ QI Work Plan ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP has adopted statewide standards for timely access

SECTION A NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
E.	The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services. (42 C.F.R. § 438.206(c)(1)(i).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Provider contract boilerplate ☐ Service Request Logs ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHPs must provide or arrange for the provision of SMHS in a timely manner appropriate for the nature of the beneficiary's condition consistent with good clinical practice. • MHPs must take into account the urgency for the need for services. • Review evidence the MHP has adopted statewide standards for timely access (Welf. & Inst. Code, § 14197(d)(1); Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)(D).): o For psychiatry appointments - within 15 business days from request to appointment o For non-urgent appointments with a non-physician mental health care provider – within 10 business days from request to appointment o Urgent care appointments for services that do not require prior authorization – within 48 hours of the request for an appointment o Urgent care appointments for services that do require prior authorization – within 96 hours of the request for an appointment

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
F.	The MHP shall implement mechanisms to assess the accessibility of services within its service delivery area. This shall include: 1. The assessment of responsiveness of the MHP's 24-hour toll-free telephone number, 2. Timeliness of scheduling routine appointments, 3. Timeliness of services for urgent conditions, and, 4. Access to after-hours care. (MHP Contract, Ex. A, Att. 8)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Assessment reports ☐ QI Work Plan ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP has adopted statewide standards for timely access.
G.	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).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Provider contract(s) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review provider contracts for hours of operation.

SECTION A NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
H.	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).) 1. The MHP shall monitor network providers regularly to determine compliance with timely access requirements. (42 C.F.R. § 438.206(c)(1)(v).) 2. The MHP shall take corrective action if there is a failure to comply with timely access requirements. (42 C.F.R. § 438.206(c)(1)(vi).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Evidence the MHP is monitoring timely access (e.g., tracking tools, database, etc.) ☐ Monitoring process and tools ☐ Provider contract boilerplate ☐ Service request logs ☐ Timely access data ☐ Evidence of corrective action plans ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • "Network providers" means organizational, group and individual providers delivering SMHS on behalf of the MHP, including county-owned/operated providers. • Review provider contracts to verify inclusion of the MHP's timeliness standards. • Review timeliness data that indicates standards are being met (e.g. timeline for first appointment). • Review monitoring results and evidence of MHP action(s) when or if providers do not meet timeliness standards. • Review evidence that the MHP has policies and processes in place to take corrective action, when needed. Review a random sample of corrective actions issued to providers during the triennial review period.

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
II.	***Access to Out-of-Network Providers***			
A.	If the MHP's provider network is unable to provide necessary services to a particular beneficiary, the MHP shall adequately and timely cover the services out of network, for as long as the MHP's provider network is unable to provide them. (MHP Contract, Ex. A, Att. 7; 42 C.F.R. § 438.206(b)(4).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ 24/7 Access Line call scripts ☐ Beneficiary handbook ☐ Evidence out-of-network services offered to beneficiaries ☐ Evidence of payments to out-of-network providers ☐ Staff training materials ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP has a mechanism in place to permit out-of-network access to beneficiaries. • The MHP must ensure that the cost to the beneficiary for services provided out of network pursuant to an authorization is no greater than it would be if the services were furnished within the MHP's network, consistent with California Code of Regulations., title 9, section 1810.365.
B.	*The MHP shall require that out-of-network providers coordinate authorization and payment with the MHP. (MHP Contract, Ex. A, Att. 7; 42 C.F.R. § 438.206(b)(5).)*			

SECTION A **NETWORK ADEQUACY AND AVAILABILITY OF SERVICES**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
III.	***Children's Services***			
A.	The MHP must provide Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) to all children and youth who meet medical necessity criteria for those services. Membership in the Katie A. subclass is not a prerequisite to receiving ICC and IHBS. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ ICC/IHBS service criteria ☐ List of beneficiaries receiving ICC/IHBS ☐ Referral forms ☐ Log of referrals of children/youth to the MHP ☐ POS data

B.	The MHP has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need ICC and IHBS. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			☐ Provider contracts ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • It is expected that Katie A. subclass members will continue to receive ICC, and IHBS when medically necessary. • Review evidence the MHP has a mechanism to track referrals from the county child welfare department. • Review evidence the MHP tracks referrals to MCP partners for non-specialty mental health services. • Review evidence the MHP provides a Notice of Adverse Benefit Determination to children/youth determined not to meet SMHS criteria and referred to MCP. • Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Core Practice Model (CPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a youth, his/her family and involved child-serving systems. • ICC is intended to link beneficiaries to beneficiaries to services provided by other child-serving systems; to facilitate teaming; and to coordinate mental health care. • If a beneficiary is involved with two or more child-serving systems, the child should be getting ICC, and the MHP should utilize ICC to facilitate cross-system communication and planning. • The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case

				managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child/youth and family in attaining their goals. ICC also provides an ICC coordinator who: ○ Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child/youth; ○ Facilitates a collaborative relationship among the child/youth, his/her family and systems involved in providing services to the child/youth; ○ Supports the parent/caregiver in meeting their child/youth's needs; ○ Helps establish the CFT and provides ongoing support; and ○ Organizes and matches care across providers and child serving systems to allow the child/youth to be served in his/her community • Intensive Home Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family's ability to help the child/youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the Core Practice Model (CPM) by the Child and Family Team (CFT) in coordination with the family's overall service

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CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
				plan which may include IHBS. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. IHBS is provided to beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service.

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	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).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Network adequacy data ☐ Provider contracts ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP is assessing its capacity to serve children/youth eligible for ICC and IHBS services. • Review evidence the MHP's network of providers have the capacity to provide ICC and IHBS services. • Review evidence the MHP meets timely access standards for the provision of ICC and IHBS. • The MHP shall not require prior authorization for ICC. • The MHP shall require prior authorization for IHBS.

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
D.	1) The Child and Family Team (CFT) composition always, 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, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ CFT meeting agendas and minutes, including list of meeting participants ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • ICC is intended to link beneficiaries to beneficiaries to services provided by other child-serving systems; to facilitate teaming; and to coordinate mental health care. • Verify that for children or youth who are receiving ICC, IHBS, or TFC, a CFT occurs at least every 90 days. • Review evidence the MHP ensures its participation, or the participation of representatives from the mental health treatment team, as appropriate, in CFT meetings when the MHP is not responsible for convening the CFT. • Review evidence the MHP takes responsibility for convening the CFT for children/youth who are receiving ICC, IHBS, or TFC, but who are not involved in the child welfare or juvenile probation systems. • Review communications and coordination among CFT members to verify participation of children/youth and their families. • Review evidence the CFT included an interpreter, if appropriate, to ensure effective communication and clear understanding of all participants.
	2) The MHP convenes 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, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
E.	There is an established ICC Coordinator, as appropriate, who serves as the single point of accountability. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ List of beneficiaries receiving ICC/IHBS ☐ List of assigned ICC Coordinator(s) ☐ Duty statement of ICC Coordinator(s) ☐ Beneficiary assessments of strengths and needs ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • A key element of ICC is the establishment of an ICC coordinator, who is often an MHP employee or contractor. • The ICC Coordinator and the CFT should reassess the strengths and needs of children and youth and their families, at least every 90 days, and as needed. • Intervention strategies should be continually monitored, so that modifications can be made based on results. • The ICC coordinator conducts referral, linkages, monitoring and follow-up activities, to ensure that the child's/youth's needs are met. This includes ensuring that services are being furnished in accordance with the child's/youth's plan, and that services are adequate to meet the child's/youth's needs. • The ICC coordinator makes recommendations to the CFT members regarding the necessary changes to the client plan, and works with the CFT and other providers to make these adjustments.

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
F.	The MHP must provide Therapeutic Foster Care (TFC) services to all children and youth who meet medical necessity criteria for TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ TFC service criteria ☐ List of beneficiaries receiving TFC ☐ POS data, if available ☐ Provider contracts ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Membership in the Katie A. subclass is not a prerequisite to receiving TFC. • It is not necessary for a child or youth to have an open child welfare case, or be involved in juvenile probation, to be considered for TFC.
G.	The MHP has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			
IV.	***The Bronzan-McCorquodale Act (1991 Realignment) Services***			
A.	The County uses its 1991 Realignment funding to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in Institutions for Mental Disease (IMD), to target populations. (MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 5600 (a); 5600.4(f); 5600.5(e); 5600.6(e); and 5600.7(e).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Program brochures ☐ Evidence services are provided to the target populations ☐ Provider contracts

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	The MHP is required to cover acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older. (MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 14053(a) and (b)(3); 42 U.S.C. § 1396d(a)(29)(B), (a)(16) & (h)(1)(c); 42 C.F.R. §§ 441.13 and 435.1009)			☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Counties are required to provide services to target populations, including adults and older adults who have a serious mental disorder, whether or not they are a Medi-Cal beneficiary. This includes individuals who are indigent or uninsured. • The County is required to pay for these services for its eligible residents, including Medi-Cal beneficiaries between the ages of 21 and 65 years old, unless the County can demonstrate, to DHCS' satisfaction, that it does not have adequate funding. • FFP is available for counties, as appropriate, for services and coverage of Medi-Cal beneficiaries under the age of 21, or 65 years or older. • Due to the IMD exclusion, FFP is not available for acute psychiatric inpatient hospital services provided in an IMD to Medi-Cal beneficiaries between the ages of 21 and 65 years old. The availability of FFP is not a factor involved in determining the county's responsibility to provide these services.

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	Assertive outreach should make mental health services available to homeless and hard-to-reach individuals with mental disabilities. (WIC §5600.2(d).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Outreach calendars and tracking reports ☐ Fliers, outreach posters, sign-in sheets from community events ☐ Mobile response unit schedule/calendar ☐ Evidence of referrals or linkages with other social service agencies/services (e.g., child welfare, homeless shelters, veterans services, law enforcement, churches, schools, etc.) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence of assertive outreach to persons who are homeless or hard-to-reach (e.g., calendar of events, sign-in sheets, tracking logs, etc.). • "Hard-to-reach individuals" refers to any special population as defined by the MHP (e.g., older adults, veterans, homebound individuals or geographically hard to reach).

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
V.	***Access to Culturally Appropriate Providers***			
A.	1) The MHP has documented evidence it has alternatives and options available, within client-driven/operated recovery and wellness programs that accommodate individual preference and racially, ethnically, culturally and linguistically diverse differences. (DMH IN No., 10-02)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Program brochures ☐ Cultural competence plan ☐ Provider contracts ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP offers culturally appropriate alternatives and options to racially, ethnically, linguistically, and culturally diverse populations.
	2) The MHP has documented evidence that its, and its network providers, has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community-based, culturally-appropriate, non-traditional mental health provider. (DMH IN No., 10-02)			
	3) The MHP has documented evidence of outreach for informing underserved populations of the availability of cultural and linguistic services and programs. (DMH IN No., 10-02)			

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	1) The MHP shall permit an American Indian beneficiary who is eligible to receive services from an Indian health care provider (IHCP) participating as a network provider, to choose that IHCP as his or her provider, as long as that provider has capacity to provide the services. (42 C.F.R. § 438.14(b)(3).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Provider contracts with IHCPs in the county ☐ Evidence the MHP offers out-of-network access to Indian beneficiaries ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP has a mechanism to permit out-of-network access to IHCPs for Indian beneficiaries. • Review evidence the MHP has made good-faith efforts to contract with any IHCPs in the county. • Please note: Not every county has an IHCP; but all MHPs must provide out-of-network access to beneficiaries. • Review evidence the IHCPs are listed in the MHP's provider directory.
	2) The MHP shall demonstrate it has sufficient IHCPs participating in its provider network to ensure timely access to services available under the contract from such providers for American Indian beneficiaries who are eligible to receive services. (42 C.F.R. § 438.14(b)(1).)			
	3) The MHP shall permit American Indian beneficiaries to obtain covered services from out- of-network IHCPs if the beneficiaries are otherwise eligible to receive such services. (42 C.F.R. § 438.14(b)(4).) The MHP shall permit an out-of-network IHCP to refer an Indian beneficiary to a network provider. (42 C.F.R. § 438.14(b)(6).)			

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
VI.	***Provider Selection and Monitoring***			
A.	The MHP shall provide a beneficiary's choice of the person providing services to the extent possible and appropriate. (CCR, tit. 9, §1830.225(a) and 42 C.F.R. § 438.3(l).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary handbook ☐ Change of provider request forms ☐ Change of provider request log **GUIDANCE:** • Review county-specific language in the handbook • Review change of provider request forms and log entries • Determine if the MHP imposes any limitations on a beneficiary's choice of network provider

SECTION A NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	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(b).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary handbook ☐ Change of provider request forms ☐ Change of provider request log **GUIDANCE:** • Review county-specific language in the handbook • Review change of provider request forms and log entries • Note: At the election of the MHP, the MHP may limit the beneficiary's choice of another person to provide services, to either an individual provider contracting with the MHP, or to another person providing services who is employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary. • Determine if the MHP imposes any limitations on a beneficiary's choice of network provider
C.	1) The MHP shall have written policies and procedures for selection and retention of providers. (42 C.F.R. § 438.214(a).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____

SECTION A NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	2) The MHP's policies and procedures for selection and retention of providers must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. (42 C.F.R. §§ 438.12(a)(2), 438.214(c).)			☐ Recruitment announcements (e.g., requests for proposals, job postings) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures • Determine the provider selection process, including method of selection (e.g., requests for proposals), contracting/hiring requirements, frequency of recruitments, etc.
	3) The MHP may not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. (42 C.F.R. § 438.12(a)(1).)			
	4) The MHP must follow a documented process for credentialing and re-credentialing of network providers. (MHSUDS IN No. 18-019; 42 C.F.R. §§ 438.12(a)(2); 438.214(b).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Recruitment announcements (e.g., requests for proposals, job postings) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures to ensure process complies with the requirements in MHSUDS IN No., 18-019

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	5) The MHP shall not employ or subcontract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 C.F.R. § 438.214(d).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Recruitment announcements (e.g., requests for proposals, job postings) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures to ensure process complies with the requirements in MHSUDS IN No., 18-019
	6) 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).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Recruitment announcements (e.g., requests for proposals, job postings) ☐ Evidence of written notice ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review notices given to providers during triennial review period. Verify notices include the reason for decision not to contract. Document reasons. • Confirm the MHP notified DHCS of its decisions not to contract with such providers.

D.	*All contracts or written agreements between the MHP and any network provider specify the following:* *1) The activities and obligations, including services provided, and related reporting responsibilities. (42 C.F.R. § 438.230(c)(1)(i).)* *2) The delegated activities and reporting responsibilities in compliance with the Contractor's obligations in this Contract. (42 C.F.R. § 438.230(c)(1)(ii).)* *3) Subcontractor's agreement to submit reports as required by the Contractor and/or the Department.* *4) The method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.* *5) Requirement that the subcontract be governed by, and construed in accordance with, all laws and regulations, and all contractual obligations of the Contractor under this contract.* *6) Requirement that the subcontractor comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions. (42 C.F.R. § 438.230(c)(2).)* *7) Terms of the subcontract including the beginning and ending dates, as well as methods for amendment and, if applicable, extension of the subcontract.*			**SUGGESTED DOCUMENTATION:** ☐ Provider contracts and written agreements, including any relevant amendments ☐ Evidence of network provider compliance with reporting requirements ☐ Evidence of corrective actions ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review selection of provider contracts/agreements. • Review evidence the MHP requires its network providers to comply with all reporting requirements.

	8) Provisions for full and partial revocation of the subcontract, delegated activities or obligations, or application of other remedies permitted by state or federal law when the Department or the Contractor determine that the subcontractor has not performed satisfactorily. (42 C.F.R. § 438.230(c)(1)(iii).) *9) The nondiscrimination and compliance provisions of this contract as described in Exhibit E, Section 5, Paragraph C and Section 6, Paragraph C.* *10) A requirement that the subcontractor make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services and activities furnished under the terms of the subcontract, or determinations of amounts payable available at any time for inspection, examination or copying by the Department, CMS, HHS Inspector General, the United States Comptroller General, their designees, and other authorized federal and state agencies. (42 C.F.R. §438.3(h).) This audit right will exist for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. (42 C.F.R. § 438.230(c)(3)(iii).) The Department, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time if there is a*			

SECTION A NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

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	reasonable possibility of fraud or similar risk, then. (42 C.F.R. § 438.230(c)(3)(iv).) *11) The Department's inspection shall occur at the subcontractor's place of business, premises or physical facilities, in a form maintained in accordance with the general standards applicable to such book or record keeping, for a term of at least ten years from the close of the state fiscal year in which the subcontract was in effect. Subcontractor's agreement that assignment or delegation of the subcontract shall be void unless prior written approval is obtained from the Contractor.* *12) A requirement that the Contractor monitor the subcontractor's compliance with the provisions of the subcontract and this contract and a requirement that the subcontractor provide a corrective action plan if deficiencies are identified.* *(MHP Contract, Ex. A, Att. 1; 42 C.F.R. § 438.230)*			

E.	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)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ MHP's Certification and Re-certification protocol ☐ Evidence of onsite certification/recertification of contracted organizational providers or county owned and operated self-certified providers ☐ Sample(s) of completed certification documentation ☐ Mechanism to track certification and re-certification status of providers ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review sample of provider certification and re-certification packets (3-5 randomly selected from provider list) to verify certification dates, fire clearance, contract, etc. • Ask the MHP how it informs and/or trains providers about relevant changes in state and federal policies and regulations. • Review evidence the MHP terminates or denies enrollment if the provider fails to permit access to provider locations for any site visits under §455.432 • When onsite review of an organizational provider is required, the MHP or DHCS, as applicable, shall conduct an onsite review at least once every three years. • The onsite review shall be made of any site owned, leased, or operated by the provider and used to deliver covered services to beneficiaries, except onsite review is not required for public school or satellite sites. • "Satellite site" means a site owned, leased, or operated by an organizational provider at which SMHS are delivered to

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
				beneficiaries fewer than 20 hours per week, or, if located at a multiagency site at which SMHS are delivered by no more than two employees or contractors of the provider.
F.	1) The MHP shall monitor the performance of its subcontractors and network providers 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) 2) If the MHP identifies deficiencies or areas of improvement, the MHP and the subcontractor shall take corrective action. (MHP Contract, Ex. A, Att. 8)			**SUGGESTED DOCUMENTATION:** ☐ Evidence of subcontractor monitoring ☐ Monitoring/performance reports ☐ Provider contracts ☐ Chart audit/monitoring tools ☐ Chart documentation manual ☐ Chart documentation training materials ☐ Chart audit reports (including reports showing disallowances) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the evidence of how the MHP monitors the individual, group and organizational providers to ensure MHP contract requirements, including documentation standards, are met. • Review MHP monitoring activities. • All types of providers (including ordering and referring providers) should be monitored for compliance with documentation standards.
VII.	***Implementation Plan***			

SECTION A NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

A.	*The MHP shall comply with the provisions of the MHP's Implementation Plan as approved by the Department. (MHP Contract, Exhibit A, Attachment 1; CCR, tit. 9, §§ 1810.310)* *The Implementation Plan shall include:* *(1) Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization.* *(2) A description of the process for:* *(A) Screening, referral and coordination with other necessary services, including, but not limited to, substance abuse, educational, health, housing and vocational rehabilitation services.* *(B) Outreach efforts for the purpose of providing information to beneficiaries and providers regarding access under the MHP.* *(C) Assuring continuity of care for beneficiaries receiving specialty mental health services.* *(D) Providing clinical consultation and training to beneficiaries' primary care physicians and other physical health care providers.* *(3) A description of the processes for problem resolution.* *(4) A description of the provider selection process, including provider selection criteria consistent with Sections 1810.425 and 1810.435.* *(5) Documentation that demonstrates that the entity:*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Implementation Plan ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • The MHP shall obtain written approval by the Department prior to making any changes to the Implementation Plan as approved by the Department. • The MHP may implement the changes if the Department does not respond in writing within thirty calendar (30) days. (CCR, tit. 9, § 1810.310(c)(5).) • The proposed Cultural Competence Plan may be a separate document pursuant to CCR, tit. 9, § 1810.410(c). • Verify Implementation Plan is reflective of current MHP policies, procedures, and practices.

SECTION A NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	(A) Offers an appropriate range of specialty mental health services that is adequate for the anticipated number of beneficiaries that will be served by the MHP, and *(B) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries that will be served by the MHP.* *(6) A description of how the MHP will deliver age–appropriate services to beneficiaries.* *(7) The proposed Cultural Competence Plan.* *(8) A description of a process for planned admissions in non–contract hospitals if such an admission is determined to be necessary by the MHP.* *(9) A description of the MHP's Quality Improvement and Utilization Management Programs.* *(10) A description of policies and procedures that assure beneficiary confidentiality in compliance with State and federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.* *(11) Other policies and procedures identified by the Department as relevant to determining readiness to provide specialty mental health services to beneficiaries.* (CCR, tit. 9, §§ 1810.310)			

SECTION B CARE COORDINATION AND CONTINUITY OF CARE

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
I.	***Coordination of Care Requirements***			
A.	1) The MHP shall ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(1).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Evidence the MHP formally designated a person(s) or entity(ies) to coordinate care for beneficiaries ☐ Documentation manual ☐ Monitoring protocols ☐ Service brochures ☐ EHR screen shots ☐ Duty statements/job descriptions ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP provides each beneficiary with a person or entity formally designated as primarily responsible for coordinating services accessed by the beneficiary
	2) The beneficiary shall be provided information on how to contact their designated person or entity. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(1).)			
B.	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; 42 C.F.R. § 438.208(b)(2)(i)-(iv), CCR, tit. 9 § 1810.415.)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Evidence of discharge planning activities

SECTION B **CARE COORDINATION AND CONTINUITY OF CARE**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	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; 42 C.F.R. § 438.208(b)(2)(i)-(iv), CCR, tit. 9 § 1810.415.)			☐ Evidence the MHP coordinates care across delivery systems ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP provides each beneficiary with a person or entity formally designated as primarily responsible for coordinating services accessed by the beneficiary • Review evidence the MHP coordinates care across delivery systems
II.	***Exchange of Information***			
A.	The MHP shall share with the Department or other managed care entities serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(4).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Release of Information forms ☐ MOU(s) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review Confidentiality/HIPAA policies and forms
B.	The MHP shall ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(5).)			

SECTION B **CARE COORDINATION AND CONTINUITY OF CARE**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	The MHP shall ensure that, in the course of coordinating care, each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R. § 160 and § 164, subparts A and E, to the extent that such provisions are applicable. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(6).)			
III.	***Coordination of Physical and Mental Health Care***			
A.	The MHP shall make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving SMHS from the MHP. (CCR, title 9, section 1810.415(a).).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Training agendas, minutes, sign-in sheets ☐ Training materials ☐ Calendar of training events ☐ Log of consultation and TA activities ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP to describe the processes in place for providing consultation and training, including consulting and training on medications. • Review evidence that clinical consultation and trainings have been conducted during the triennial review period.

SECTION B CARE COORDINATION AND CONTINUITY OF CARE

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	When the MHP determines that the beneficiary's diagnosis is not included as a SMHS, or is included but would be responsive to physical health care based treatment, the MHP of the beneficiary shall refer the beneficiary in accordance with state regulations. (CCR, tit.9, § 1810.415(d).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Referrals ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • The MHP shall not be required to ensure the beneficiary's access to physical health care based treatment or to ensure the beneficiary's access to treatment from licensed mental health professionals for diagnoses not covered as SMHS. (CCR, tit.9, § 1810.415(d).)

SECTION B **CARE COORDINATION AND CONTINUITY OF CARE**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
IV.	***MOUs with Medi-Cal Managed Care Plans***			
A.	*The MHP shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries. (MHP Contract, Ex. A, Att.10; CCR, tit. 9, § 1810.370.)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ MOU(s) with any MCP(s) in the county ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • The MHP shall notify the Department in writing if the Contractor is unable to enter into an MOU or if an MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU. (MHP Contract, Ex. A, Att.10; CCR, tit. 9, § 1810.370.) • Per Title 9, Section 1810.370, the MOUs shall address the following: o Referral protocols between plans o The availability of clinical consultation, including consultation on medications o Management of a beneficiary's care, including procedures for the exchange of medical record information o Procedures for providing beneficiaries with services necessary to the treatment of mental illnesses covered by the MHP o A process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services

SECTION B **CARE COORDINATION AND CONTINUITY OF CARE**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	*The MHP shall monitor the effectiveness of its MOU with Medi-Cal managed care plans. (MHP Contract, Ex. A, Att.10; CCR, tit. 9, § 1810.370.)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Monitoring tools ☐ Minutes from MCP coordination meetings ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP to describe process for monitoring and assessing the effectiveness of MOU(s) with physical health care plans.
C.	*The MOU addresses the referral protocol between the MHP and MCP, including:* *1) How the MHP will provide a referral to the MCP when the MHP determines that the beneficiary's mental illness would be responsive to physical health care based treatment. (CCR, title 9, section 1810.370(a)(1):*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Referral protocol, forms and/or tools ☐ Referral tracking mechanism ☐ Sample referrals ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP to describe referral procedures between MHP and MCP. • MHP to describe mechanism for tracking referrals between MHP and MCP.
	2) How the MCP will provide a referral to the MHP when the MCP determines SMHS covered by the MHP may be required. (CCR, title 9, section 1810.370(a)(1):			

SECTION B **CARE COORDINATION AND CONTINUITY OF CARE**

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	3) Management of a beneficiary's care, including procedures for the exchange of medical record information. (CCR, title 9, section 1810.370(a)(1).)			• Review evidence the MHP sends beneficiaries a Notice of Adverse Benefit Determination when referring a beneficiary to the MCP. • Prescription drugs and laboratory services procedures shall include the requirements specified in CCR, title 9, section 1810.370(a)(4). • The procedures for providing beneficiaries with services…shall address the following (CCR, title 9, section 1810.370(a)(1): o Prescription drugs and laboratory services covered by the MCP and prescribed through the MHP; o Emergency room facility and related services other than SMHS; o Homes health agency services; o Non-emergency medical transportation; o Services to treat the physical health care needs of beneficiaries who are receiving psychiatric inpatient hospital services, including the history and physical required upon admission; and, o Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a beneficiary's mental health or medical condition.
	4) Procedures for providing beneficiaries with services necessary to the treatment of mental illness covered by the MHP when those necessary services are covered by the MCP. (CCR, title 9, section 1810.370(a)(1).)			

SECTION B **CARE COORDINATION AND CONTINUITY OF CARE**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
D.	*1) The MHP has a process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the disputes is being resolved. (CCR Title 9 § 1810.370(a)(5)).*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ MOU(s) with MCP(s) ☐ Evidence of notification to beneficiaries (e.g., templates, samples, etc.) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP to describe process for resolving disputes between MHP and MCP. • Review evidence of MOU language which ensures a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the dispute is being resolved. • Review evidence the MHP provides medically necessary services to beneficiaries while a dispute is pending.
	2) When the dispute involves an MCP continuing to provide services to a beneficiary the MCP believes requires SMHS from the MHP, the MHP shall identify and provide the MCP with the name and telephone number of a psychiatrist or other qualified LMHP available to provide clinical consultation, including consultation on medications to the MCP provider responsible for the beneficiary's care. (CCR Title 9 § 1810.370(a)(5)).			
V.	***Continuity of Care***			

SECTION B **CARE COORDINATION AND CONTINUITY OF CARE**

A	*1) The MHP must establish continuity of care procedures in accordance with MHSUDS IN 18-059. The procedures must address the following requirements:* ○ *Beneficiaries with pre-existing provider relationships who make a continuity of care request to the MHP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider (i.e., an employee of the MHP or a contracted organizational provider, provider group, or individual practitioner);* ○ *SMHS shall continue to be provided, at the request of the beneficiary, for a period of time, not to exceed 12 months, necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by the MHP, in consultation with the beneficiary and the provider, and consistent with good professional practice;* ○ *A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a direct request to the MHP for continuity of care;* ○ *Beneficiaries may request continuity of care in person, in writing, or via telephone and shall not be required to*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Continuity of care requests ☐ Evidence of notification to beneficiaries (e.g., templates, samples, etc.) ☐ Continuity of care tracking mechanism and data reports ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures to ensure compliance with MHSUDS IN 18-059. • Review continuity of care requests and logs

SECTION B **CARE COORDINATION AND CONTINUITY OF CARE**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	submit an electronic or written request; and, ○ *The MHP must provide reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation and auxiliary aids and services. (MHSUDS IN 18-059)*			
B.	*Following identification of a pre-existing relationship with an out-of-network provider, the MHP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of formal relationship to establish continuity of care for the beneficiary. (MHSUDS IN 18-059)*			

SECTION B **CARE COORDINATION AND CONTINUITY OF CARE**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	*Each continuity of care request must be completed within the following timelines:* ○ *Thirty calendar days from the date the MHP received the request;* ○ *Fifteen calendar days if the beneficiary's condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,* ○ *Three calendar days if there is a risk of harm to the beneficiary. (MHSUDS IN 18-059)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Continuity of care requests ☐ Evidence of notification to beneficiaries (e.g., templates, samples, etc.) ☐ Continuity of care tracking mechanism and data reports ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures to ensure compliance with MHSUDS IN 18-059. • Review continuity of care requests and logs to ensure requests are completed within specified timeframes.
D.	*If the provider meets all of the required conditions and the beneficiary's request is granted, the MHP must allow the beneficiary to have access to that provider for a period of up to 12-months, depending on the needs of the beneficiary and the agreement made between the MHP and the out-of-network provider. (MHSUDS IN 18-059)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Continuity of care requests ☐ Provider agreements/single-case agreements ☐ Continuity of care tracking mechanism and data reports ☐ Other evidence deemed appropriate by review team

SECTION B **CARE COORDINATION AND CONTINUITY OF CARE**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
E.	*When the continuity of care agreement has been established, the MHP must work with the provider to establish a Client Plan and transition plan for the beneficiary. (MHSUDS IN 18-059)*			**GUIDANCE:** • Review the MHP's policies and procedures to ensure compliance with MHSUDS IN 18-059. • Review continuity of care requests and logs to ensure requests are granted for a period of up to 12-months. • Review scope of work of executed provider agreements pertaining to continuity of care arrangements.
F.	*Upon approval of a continuity of care request, the MHP must notify the beneficiary and/or the beneficiary's authorized representative, in writing, of the following:* *1) The MHP's approval of the continuity of care request;* *2) The duration of the continuity of care arrangement;* *3) The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and,* *4) The beneficiary's right to choose a different provider from the MHP's provider network. (MHSUDS IN 18-059)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Continuity of care requests ☐ Evidence of notification to beneficiaries (e.g., templates, samples, etc.) ☐ Continuity of care tracking mechanism and data reports ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures to ensure compliance with MHSUDS IN 18-059. • Review beneficiary notifications.

SECTION B **CARE COORDINATION AND CONTINUITY OF CARE**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
G.	*The written notification to the beneficiary must comply with Title 42 of the Code of Federal Regulations, part 438.10(d) and include the following:* ○ *The MHP's denial of the beneficiary's continuity of care request;* ○ *A clear explanation of the reasons for the denial;* ○ *The availability of in-network SMHS;* ○ *How and where to access SMHS from the MHP;* ○ *The beneficiary's right to file an appeal based on the adverse benefit determination; and,* ○ *The MHP's beneficiary handbook and provider directory. (MHSUDS IN 18-059)*			
H.	*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 his or her care at the end of the continuity of care period. (MHSUDS IN 18-059)*			

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
I.	***Quality Assessment and Performance Improvement Program***			
A.	The MHP has a written description of the Quality Assessment and Performance Improvement (QAPI) Program that: 1. Clearly defines its structure and elements, 2. Assigns responsibility to appropriate individuals, and 3. Adopts or establishes quantitative measures to assess performance and identify and prioritize areas for improvement. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.330(a)(e)(2).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QAPI Program Description ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review QAPI Program description to verify it includes all required elements • QAPI Program is inclusive of Quality Improvement (QI) • QI Program description and work plan may be offered as evidence of compliance for the QAPI program requirements if all required elements are included.
B.	*The MHP evaluates the impact and effectiveness of the QAPI Program annually and updates the Program as necessary. (MHP Contract, Ex. A, Att. 5; CCR, title 9, section 1810.440(a)(6).)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Annual QAPI Program Evaluations ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence of annual QAPI Program evaluations, including goals met, continued or modified and the rationale for selecting new goals

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	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; 42 C.F.R. § 438.330(a)(e)(2).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QAPI Work Plan ☐ Evidence of performance monitoring ☐ Performance data reports ☐ Other evidence deemed appropriate by the review team **GUIDANCE:** • Review evidence the MHP conducts performance monitoring activities.
D.	*The MHP shall have mechanisms to detect both underutilization and overutilization of services. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.330(b)(3).)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QAPI Work Plan ☐ Utilization data reports ☐ EQRO reports ☐ Other evidence deemed appropriate by the review team **GUIDANCE:** • Review evidence the MHP has mechanisms to detect under and over-utilization of services • Review utilization reports and trends analyses • Review DHCS POS data across fiscal years

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
E.	1) The MHP has mechanisms to assess beneficiary/family satisfaction by surveying beneficiary/family satisfaction at least annually. (MHP Contract, Ex. A, Att. 5)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary/Family Satisfaction Survey Sample ☐ Survey Results ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence surveys were conducted in all threshold languages. • Activities related to beneficiary satisfaction can include surveys, outreach, education, focus groups, and other related activities. • Refer to current External Quality Review Organization (EQRO) report regarding consumer satisfaction survey, if applicable. • Review evidence of changes made based on results.
	2) The MHP has mechanisms to assess beneficiary/family satisfaction by evaluating beneficiary grievance, appeals and fair hearings at least annually. (MHP Contract, Ex. A, Att. 5)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QI agenda and minutes ☐ Analysis of grievances, appeals, and fair hearings ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP is evaluating beneficiary grievances, appeals, fair hearings to determine if there are trends or areas needing quality improvement.

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	3) The MHP shall inform providers of the beneficiary/family satisfaction activities. (MHP Contract, Ex. A, Att. 5)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample(s) notification(s) to providers ☐ Beneficiary/family satisfaction reports ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review MHP's mechanism for informing providers of results. • Does the MHP have a procedure for addressing any negative survey results with providers?

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
F.	*The MHP shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be:* *1. Under the supervision of a person licensed to prescribe or dispense medication.* *2. Performed at least annually.* *3. Inclusive of medications prescribed to adults and youth.* *(MHP Contract, Ex. A, Att. 5)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Prescribing practice guidelines ☐ Monitoring tools ☐ Monitoring results ☐ Training protocols ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • The monitoring mechanism must be under the supervision of a person licensed to prescribe or dispense prescription drugs. • Review the policy to determine if it specifically addresses monitoring psychotropic medication use for children / youth. • Review evidence of psychotropic medication monitoring by the MHP. • Review evidence of corrective actions taken to address quality of care concerns related to psychotropic medication use.

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
G.	The MHP has mechanisms to address meaningful clinical issues affecting beneficiaries system-wide. (MHP Contract, Ex. A, Att. 5)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QAPI Work Plan ☐ QIC agendas and/or minutes ☐ Clinical Performance Improvement Projects (PIPs)/(EQRO) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP to describe mechanisms to address meaningful clinical issues affecting beneficiaries system wide. • MHP to describe clinical PIPs during triennial period.
H.	The Contractor has mechanisms to: 1. Monitor appropriate and timely intervention of occurrences that raise quality of care concerns. 2. Take appropriate follow-up action when such an occurrence is identified. 3. Evaluate the results of the intervention at least annually. (MHP Contract, Ex. A, Att. 5)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QAPI Work Plan ☐ QIC agendas and/or minutes ☐ Monitoring tools ☐ Monitoring results ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP to describe mechanisms to monitor quality of care occurrences and appropriate follow up action.

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
II.	***QAPI Work Plan***			
A.	*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)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QAPI Work Plan ☐ QAPI Work Plan evaluations ☐ QIC agendas and/or minutes ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's QAPI Work Plan for required contractual elements. • Review the QI Evaluations for goals, completed goals, goals continued from year to year, and new goals each year.

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	*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 fair hearings, provider appeals, and clinical records review. (MHP Contract, Ex. A, Att. 5)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QAPI Work Plan ☐ QAPI Work Plan evaluations ☐ QIC agendas and/or minutes ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's QAPI Work Plan for required contractual elements.
C.	*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)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QAPI Work Plan ☐ QAPI Work Plan evaluations ☐ QIC agendas and/or minutes ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's QAPI Work Plan for required contractual elements.

SECTION C **QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
D.	*The QAPI work plan includes a description of completed and in-process QAPI activities, including:* *1) Monitoring efforts for previously identified issues, including tracking issues over time.* *2) Objectives, scope, and planned QAPI activities for each year.* *3) Targeted areas of improvement or change in service delivery or program design.* (MHP Contract, Ex. A, Att. 5)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QAPI Work Plan ☐ QAPI Work Plan evaluations ☐ QIC agendas and/or minutes ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's QAPI Work Plan for required contractual elements. • Review the QI Evaluations for goals, completed goals, goals continued from year to year, and new goals each year.

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
E.	*The QAPI work plan includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals for:* *1) Responsiveness for the Contractor's 24-hour toll-free telephone number.* *2) Timeliness for scheduling of routine appointments.* *3) Timeliness of services for urgent conditions.* *4) Access to after-hours care.* (MHP Contract, Ex. A, Att. 5)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QAPI Work Plan ☐ QIC agendas and/or minutes ☐ Monitoring tools ☐ Monitoring results ☐ Test Call procedures ☐ Provider contracts ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP to have standards/goals for accessibility of services and mechanisms to assess services within its service delivery area.

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
F.	*The QAPI work plan includes evidence of compliance with the requirements for cultural competence and linguistic competence. (MHP Contract, Ex. A, Att. 5)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QAPI Work Plan, ☐ QIC agendas and/or minutes ☐ Cultural Competence Plan ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP has a current Cultural Competence Plan. • Review evidence the QAPI Work Plan includes goals and activities related to cultural and linguistic competence.

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
III.	***Quality Improvement Committee (QIC)***			
A.	1) The MHP shall establish a QIC to review the quality of SMHS provided to beneficiaries.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QIC Charter ☐ QIC agenda and minutes ☐ Evidence of planning, design and execution activities ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence of the involvement of providers, beneficiaries, and family members in planning, design, and execution of the QI program, including evaluating data. • Review evidence of the MHP's recruitment and selection process for participation in the QI program
	2) The QIC shall: a. Recommend policy decisions. b. Review and evaluate the results of QI activities, including performance improvement projects (PIPs). c. Institute needed QI actions. d. Ensure follow-up of QI processes. e. Document QI committee meeting minutes regarding decisions and actions taken. (MHP Contract, Ex. A, Att. 5)			

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	The MHP QAPI program includes active participation by the MHP's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the QI program. (MHP Contract, Ex. A, Att. 5)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QIC roster ☐ QI agenda and minutes ☐ Evidence of planning, design and execution activities ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence of the involvement of providers, beneficiaries, and family members in planning, design, and execution of the QI program, including evaluating data. • Review evidence of the MHP's recruitment and selection process for participation in the QI program
C.	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)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Data to measure against identified goals ☐ QI agenda and minutes ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP should have baseline statistics with goals for the year, as well as, annual evaluations and updates. • Review data used to measure against identified goals.

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
D.	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)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ QI agenda and minutes ☐ Samples of input received ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP to describe mechanisms for obtaining input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services.
IV.	***Performance Improvement Projects (PIPs)***			
A.	*The MHP shall conduct a minimum of two PIPs per year, including any PIPs required by DHCS or CMS. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.330(b)(1) and (d)(1).)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ PIPs ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP conducted two PIPs per year. • One PIP shall focus on a clinical area and one on a non-clinical area.

SECTION C QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
V.	***Practice Guidelines***			
A.	*The MHP has practice guidelines, which meet the requirements of the MHP Contract. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ MHP's Practice Guidelines ☐ Provider Manual ☐ Provider contract boilerplate ☐ Other evidence deemed appropriate by the review team **GUIDANCE:** • The practice guidelines must meet the following requirements: ○ They are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field. ○ They consider the needs of beneficiaries. ○ They are adopted in consultation with contracting health care professionals. ○ They are reviewed and updated periodically as appropriate. ○
B.	*The MHP disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)*			
C.	*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. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)*			

SECTION D **ACCESS AND INFORMATION REQUIREMENTS**

CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
I.	***General Information Requirements***			
A.	1) The MHP shall provide information in a manner and format that is easily understood and readily accessible to beneficiaries. (42 C.F.R. § 438.10(c)(1).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ MHP website ☐ Written informing materials in alternative formats ☐ Written informing materials in alternative formats in the MHP's threshold languages ☐ Evidence the MHP's beneficiary information is provided in an easily understood and readily accessible format ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Written materials apply to informing materials (e.g. beneficiary booklet, general program literature, forms, etc.). • Review evidence of the alternative formats available. • Review evidence that large print documents are available in 18 point font. • Ask the MHP how it inform beneficiaries that information is available in alternative formats and how to access those formats.
	2) The MHP shall provide all written materials for beneficiaries in easily understood language, format, and alternative formats that take into consideration the special needs of beneficiaries. (42 C.F.R. § 438.10(d)(6).)			
	3) The MHP shall inform beneficiaries that information is available in alternate formats (e.g., large print, audio, video) and how to access those formats. (42 C.F.R. § 438.10.)			
	4) The MHP shall ensure its written materials are available in alternative formats, including large print, upon request of the potential beneficiary or beneficiary at no cost. Large print means printed in a font size no smaller than 18 point. (42 C.F.R. § 438.10(d)(3).)			

SECTION D **ACCESS AND INFORMATION REQUIREMENTS**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	5) The MHP shall operate a website that provides beneficiaries with the information required in Title 42 of the Code of Federal Regulations part 438.10. (42 C.F.R. § 438.10.)			• Review evidence the alternative formats available in the threshold language(s) (e.g., large print, audio versions, or braille).
B.	*Beneficiary information required in Title 42 of the Code of Federal Regulations part 438.10 (e.g., information about managed care, beneficiary handbook, provider directory) may only be provided electronically by the MHP if all of the following conditions are met:* *1) The format is readily accessible;* *2) The information is placed in a location on the MHP's website that is prominent and readily accessible;* *3) The information is provided in an electronic form which can be electronically retained and printed;* *4) The information is consistent with the content and language requirements of the MHP Contract; and* *5) The beneficiary is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days. (42 C.F.R. 438.10(c)(6).)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ MHP website ☐ Mechanism for informing beneficiaries ☐ Intake packets ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's website to verify information is readily accessible. • Review posted documents to verify they meet language and format requirements. • Review evidence beneficiaries are informed of the availability of the information in a paper form without charge and upon request. • Review evidence the MHP processes request for paper copies within 5 business days.

SECTION D **ACCESS AND INFORMATION REQUIREMENTS**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	The MHP shall make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider. (42 C.F.R. § 438.10(f)(1).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ MHP website ☐ Mechanism for informing beneficiaries ☐ Intake packets ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's website to verify information is readily accessible.
II.	***Language and Format Requirements***			
A.	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).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____

SECTION D **ACCESS AND INFORMATION REQUIREMENTS**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	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: 1) provider directories, 2) beneficiary handbooks, 3) appeal and grievance notices, 4) denial and termination notices, and, 5) MHP's mental health education materials, (MHP Contract, Ex. A, Att. 11; 42 C.F.R. § 438.10(d)(3).)			☐ Beneficiary handbook ☐ Provider directory ☐ Appeal and grievance notices ☐ Denial and termination notices ☐ Posted notices and signage ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Written materials apply to informing materials (e.g. beneficiary booklet, general program literature, forms, etc.). • Confirm the MHP's threshold language(s):_____ • Review the MHP's written materials to verify compliance with the language and format requirements. • The MHP shall include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the MHP's member/customer service unit. (42 C.F.R. § 438.10(d)(3).)
C.	The MHP shall include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. (42 C.F.R. § 438.10(d)(2).)			
D.	The MHP shall notify beneficiaries 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); Cal. Code Regs., tit. 9, § 1810.410, subd. (e), para. (4).)			

SECTION D ACCESS AND INFORMATION REQUIREMENTS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
E.	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)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Contracts with vendors for translated materials ☐ Samples of translated materials tested for accuracy ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review documentation the MHP has implemented a process for ensuring the accuracy of translated materials
F.	1) The MHP shall make auxiliary aids and services, such as TTY/TDY and American Sign Language (ASL), available upon request and free of charge to each beneficiary. (42 C.F.R. § 438.10(d)(3)-(4).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Evidence interpreter services are available free of charge ☐ Evidence of auxiliary aids and services ☐ Posted notices and signs ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Auxiliary aids and services include: (1) Qualified interpreters on-site or through video remote interpreting (VRI) services, as defined in 28 CFR 35.104 and 36.303(b); note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption
	2) The MHP shall notify beneficiaries how to access these services. (42 C.F.R. § 438.10(d) (5)(ii)-(iii).)			
G.	a) The MHP shall make oral interpretation, available and free of charge for any language. (42 C.F.R. § 438.10(d)(2), (4)-(5).)			
	b) The MHP shall notify beneficiaries that the service is available and how to access those services. (42 C.F.R. § 438.10(d)(5)(i), (iii).)			

SECTION D **ACCESS AND INFORMATION REQUIREMENTS**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	c) The MHP complies with the following requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973: a. Prohibiting the expectation that family members provide interpreter services. b. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services. c. Minor children should not be used as interpreters. (Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973)			decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing; (2) Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision; (3) Acquisition or modification of equipment and devices; and (4) Other similar services and actions. (45 CFR §92.4)
III.	***Beneficiary Handbook***			
A.	*The MHP shall provide beneficiaries with a copy of the beneficiary handbook when the beneficiary first accesses SMHS and thereafter upon request. (Cal. Code Regs., tit. 9, § 1810.360.)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary handbook ☐ Client Intake Packet

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	*The MHP shall ensure its beneficiary handbook includes the current toll-free telephone number(s) that provides information in all languages spoken by beneficiaries in the county and is available twenty-four hours a day, seven days a week. (Cal. Code Regs., tit. 9, § 1810.405, subd. (d).)*			☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's beneficiary handbook. • Review evidence the handbook is provided to beneficiaries when the beneficiary first accesses SMHS. • Consistent with with 42 C.F.R part 438.10(g)(3), the handbook will be considered provided if the MHP: o Mails a printed copy of the information to the beneficiary's mailing address before the beneficiary first receives a specialty mental health service; o Mails a printed copy of the information upon the beneficiary's request to the beneficiary's mailing address; o Provides the information by email after obtaining the beneficiary's agreement to receive the information by email; o Posts the information on the Contractor's website and advises the beneficiary in paper or electronic form that the information is available on the internet and includes the applicable internet addresses, provided that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or, o Provides the information by any other method that can reasonably be expected to result in the beneficiary receiving that information. If the Contractor provides the handbook in-person when the beneficiary first receives specialty mental health services, the date and method of delivery shall be documented in the beneficiary's file.

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
IV.	***Provider Directory***			
A.	*The MHP shall make its provider directories available in electronic and paper form when a beneficiary first receives a SMHS. (MHP Contract, Ex. A, Att. 11; 42 C.F.R. § 438.10 (h).)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Provider directories ☐ Client Intake Packet ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence that a provider directory is issued upon first receiving an SMHS and upon request. • Review the provider directory to verify it contains all required elements.
B.	*Information included in a paper provider directory shall be updated at least monthly and electronic provider directories shall be updated no later than 30 calendar days after the Contractor receives updated provider information. (42 C.F.R. § 438.10(h)(3).)*			
C.	*Provider directories shall be made available on the Contractor's website in a machine readable file and format as specified by the Secretary. (42 C.F.R. § 438.10(h)(4).)*			

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D.	*The MHP provider directory must contain the following required elements:* *1) Names of provider(s) and group affiliation, if any.* *2) Provider's business address(es) (e.g. physical location of the clinic or office).* *3) Telephone number(s).* *4) Email address(es), as appropriate.* *5) Website URL, as appropriate.* *6) Specialty, in terms of training, experience and specialization, including board certification (if any).* *7) Services/modalities provided, including information about populations served (i.e., perinatal, children/youth, adults).* *8) Whether the provider accepts new beneficiaries.* *9) The provider's cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender).* *10) The provider's linguistic capabilities, including languages offered (e.g., Spanish, Tagalog, American Sign Language) by the provider or a skilled*			**SUGGESTED DOCUMENTATION:** ☐ Provider directory ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • When reviewing larger counties, a regionalized provider list is acceptable. • The provider directory should include county owned and operated providers, contracted organizational providers, provider groups, and individual practitioners including. Small counties may only have county owned and/or operated providers. • The provider directory shall include licensed, waivered, or registered mental health provider and licensed substance use disorder services provider employed by the MHP. • Provider directory should include child/youth and adult/older providers. • At a minimum, the services are to be categorized by psychiatric inpatient hospital, Mental Health Services, Targeted Case Management, Intensive Care Coordination, Intensive Home Based Services, Therapeutic Foster Care (agency), TBS and/or all other SMHS. • The provider directory shall also include the following notation (may be included as a footnote); "Services may be delivered by an individual provider, or a team of providers, who is working under the direction of a licensed practitioner operating within their scope of practice. Only licensed, waivered, or registered mental health providers and licensed substance use disorder services providers are listed on the Plan's provider directory." • If the MHP delegate the requirement to list individuals employed by provider organizations to its providers, ensure the MHP's

SECTION D ACCESS AND INFORMATION REQUIREMENTS

	CRITERIA	FINDING Y	N	INSTRUCTIONS TO REVIEWERS
	medical interpreter at the provider's office. *11) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.* *12) Type of practitioner, as appropriate* *13) National Provider Identifier* *14) California license number and type of license* *15) An indication of whether the provider has completed cultural competence training.* *(42 C.F.R. § 438.10(h)(1)(v), CCR, title 9, chapter 11, section 1810.410, MHSUD IN 18-020).*			website links to the provider organization's website and vice versa. Alternately, the MHP may elect to maintain this information at the county level. • Review the evidence that the MHP monitors the network provider's compliance with Provider Directory requirements. • The provider directory should be current and accurately reflect providers accepting new Medi-Cal beneficiaries. • MHP may denote providers accepting new beneficiaries by adding a footnote instructing beneficiaries to contact providers. • Specialty may include specialization in trauma-informed care. • Alternatives and options for culturally appropriate services may include services for transition-age youth, veterans, older adults, Lesbian, Gay, Bisexual, and Transgender or Questioning (LGBTQ), etc. • Review evidence the MHP is monitoring cultural competence training of providers. • Review evidence the MHP updates the information included in its paper provider directory at least monthly and the electronic directory no later than 30 calendar days after the MHP receives updated provider information. • Review evidence the provider directory is available on the MHP's website in a machine readable file and format.

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CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
V.	***Advance Directives***			
A.	*The MHP shall maintain written policies and procedures on advance directives, which include a description of applicable California law. (42 C.F.R. §§ and 438.3(j)(1)-(3), 422.128).*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures
B.	*The MHP shall provide adult beneficiaries with the written information on advance directives. (42 C.F.R. § 438.3(j)(3).)*			
VI.	***24/7 Access Line and Written Log of Requests for SMHS***			
A.	The MHP provides training for staff responsible for the statewide toll-free 24-hour telephone line to ensure linguistic capabilities. (CCR, title 9, chapter 11, sections 1810.410 (c) (4)).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Documentation of training plan, training records, and training activities ☐ Training materials ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence of training for all staff responsible for the 24/7 statewide toll-free telephone line • Ask the MHP about frequency and content of training

SECTION D ACCESS AND INFORMATION REQUIREMENTS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: 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. 2) The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met. 3) The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition. 4) The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes. (CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).)			**SUGGESTED DOCUMENTATION:** ☐ DHCS test call worksheets ☐ Policies and Procedures #_____ ☐ Contracts/documentation of vendors providing language access for 24/7 statewide toll free line ☐ Test call scripts ☐ MHP test call results ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • DHCS review team members will test the 24/7 toll-free telephone number in English and other language(s). • Information should be made available to all callers without regard to Medi-Cal status. • Results for each requirement will be calculated based on the test call findings.

SECTION D ACCESS AND INFORMATION REQUIREMENTS

CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	1) 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, title 9, chapter 11, section 1810.405(f)).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Written Log(s) of Initial Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the log(s) are maintained for all requests made by phone, in person or in writing. MHP may maintain the log electronically. Records shall be maintained in accordance with 42 C.F.R. sections 438.3(u) and (h). • Review the written logs for required information pertaining to the DHCS test calls. • Test calls only requesting information about the MHP's Problem Resolution and State Fair Hearing processes are not required by regulation to be logged. • Initial dispositions may include, but are not limited to: caller provided with clinic hours/location, beneficiary scheduled for assessment with [Provider] at [Date/time], warm hand off to 24 hour Crisis Clinician, etc. • Review the written logs for required information pertaining to the DHCS test calls. • Initial dispositions may include, but are not limited to: caller provided with clinic hours/location, beneficiary scheduled for assessment with [Provider] at [Date/time], warm hand off to 24 hour Crisis Clinician, etc.
	2) The written log(s) contain the following required elements: a) Name of the beneficiary. b) Date of the request. c) Initial disposition of the request. (CCR, title 9, chapter 11, section 1810.405(f).)			

SECTION D **ACCESS AND INFORMATION REQUIREMENTS**

CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
VII.	***Cultural Competence Requirements***			
A.	*The MHP has updated its Cultural Competence Plan annually in accordance with regulations. (CCR title 9, section 1810.410)*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Cultural Competence Plan ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's Cultural Competence Plan to determine if it has been updated annually during the triennial review period. • Review data collected (Criterion 2) and strategies identified (Criterion 3) in the CCP. • Ask the MHP how it determines priorities for strategies from year to year.
B.	Regarding the MHP's Cultural Competence Committee (CCC): 1) The MHP has a CCC or other group that addresses cultural issues and has participation from cultural groups that is reflective of the community. (CCR title 9, section 1810.410).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Organizational Chart ☐ CCC Agendas and Meeting Minutes ☐ Cultural Competence Plan ☐ QI Program review documentation

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	2) The MHP has evidence of policies, procedures, and practices that demonstrate the CCC activities include the following: a) Participates in overall planning and implementation of services at the county. b) Provides reports to the Quality Assurance and/or the Quality Improvement Program. (CCR title 9, section 1810.410)			☐ QIC Agendas and Minutes ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies, procedures, and practices that assure members of the CCC will be reflective of the community including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, youth and families, providers, community partners, contractors, and other members as necessary (CCPR Criterion 4). • If the MHP does not have a CCC, review evidence another committee or group reviews cultural competence issues (e.g., Quality Improvement Committee). • Review evidence the CCC (or another committee focused on cultural competence) participates in overall planning and implementation of services at the county. • Review evidence of the CCC's policy and planning recommendations and the MHP's response • Review evidence the CCC reports to the QI Program

SECTION D ACCESS AND INFORMATION REQUIREMENTS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	The CCC completes its Annual Report of CCC activities as required in the CCPR. (CCR title 9, section 1810.410).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ CCC Annual Report(s) ☐ Cultural Competence Plan ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's Cultural Competence Plan • Review completed CCC reports • Annual report of activities to include: o Goals and objectives of the committee o Evaluation of goals and objectives o Reviews and recommendations to county programs and services, as well as actions taken o Goals of Cultural Competence Plans o Human Resources report (i.e., workforce development and/or recruitment activities) o County organizational assessment o Training plans
D.	Regarding the MHP's plan for annual cultural competence training necessary to ensure the provision of culturally competent services: 1) There is a plan for cultural competency training for the administrative and management staff of the MHP.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Cultural Competence Plan ☐ Cultural Competence Training Plan

SECTION D ACCESS AND INFORMATION REQUIREMENTS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	2) There is a plan for cultural competency training for persons providing SMHS employed by or contracting with the MHP.			☐ Documentation of training for administrative and management staff ☐ Documentation of training for persons providing SMHS employed by or contracting with the MHP ☐ Documentation of training for interpreters and bilingual staff ☐ Training materials/curricula ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Ask MHP to describe its process for ensuring that interpreters are trained and monitored for language competence. • Determine if pre/post tests for fluency are part of bilingual pay policy. • Ask the MHP if interpreters are trained utilizing the Mental Health Interpreter Training curriculum and/or if interpreters receive general training on mental health systems.
	3) There is a process that ensures that interpreters are trained and monitored for language competence (e.g., formal testing). (CCR, title 9, § 1810.410 (c)(4).)			

SECTION D **ACCESS AND INFORMATION REQUIREMENTS**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
E.	The MHP has evidence of the implementation of training programs to improve the cultural competence skills of staff and contract providers. (CCR, title 9, § 1810.410 (c)(4)).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Documentation of tracking mechanisms to ensure all staff receive required annual training ☐ MHP Provider Contract ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence that cultural competency training plans have been implemented during the triennial review period. • Review the MHP's Annual Training Report as required by the CCPR, DMH Information Notice 10-02. • Review evidence the MHP has a mechanism to track the participation of all staff in required cultural competence trainings. • Review evidence the MHP tracks participation of its contract providers in required cultural competence training.

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
I.	***Authorization – General Requirements***			
A.	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; 42 C.F.R. § 438.210(b)(2)(i-ii).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample Requests for Authorization ☐ Payment authorization checklist/tools ☐ UM review tools (e.g., chart review tools, inter-rater reliability tools, etc.) ☐ Approver License(s) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures. • Review service authorizations during the triennial review period. • No individual, other than a licensed physician or a licensed mental health professional who is competent to evaluate the specific clinical issues involved in the SMHS requested by a beneficiary or a provider, may deny or modify a request for
B.	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; 42 C.F.R. § 438.210(b)(3).)			
C.	The MHP shall notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor 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 6; 42 C.F.R. § 438.210(c).)			

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
D.	Compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(e).)			authorization of SMHS for a beneficiary for reasons related to medical necessity. ○ A licensed physician must approve denials for acute inpatient hospital or PHF services. • Ask the MHP to describe their UM procedures to review for consistency in authorization decisions.
E.	The MHP shall ensure that all medically necessary covered SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. (42 C.F.R., § 438.210(a)(3)(i).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review random sample of authorization requests reflecting adverse determinations (i.e., denials or modifications) by the MHP.

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
F.	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. (42 C.F.R., § 438.210(a)(3)(i).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review random sample of authorization requests reflecting adverse determinations (i.e., denials or modifications) by the MHP. • Review Notices of Adverse Benefit Determinations corresponding with denials or modifications.
II.	***Authorization Requirements for Concurrent Review and Prior Authorization***			
A.	**SURVEY ONLY** MHPs must establish and implement written policies and procedures addressing the authorization of SMHS. (MHSUDS IN 19-026)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures.

B.	**SURVEY ONLY** MHPs must comply with the following communication requirements: 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; 2) Maintain telephone access 24-hours a day, 7-days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of an outpatient service requiring prior authorization. 3) A physician shall be available for consultation and for resolving disputed requests for authorizations; 4) 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 these online; 5) Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** Review policies and procedures.

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	6) MHPs must provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization. (MHSUDS IN 19-026)			
C.	**SURVEY ONLY** MHPs are required to conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services. a. MHPs shall conduct concurrent review of treatment authorizations following the first day of admission. b. MHPs may elect to initially authorize multiple days, but each day of treatment must meet medical necessity and/or continued stay criteria. (MHSUDS IN 19-026)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures.

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
D.	**SURVEY ONLY** Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating providers, including both the hospital and treating physician, in writing, within 24 hours of the decision. 1) If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination. 2) In the case of concurrent review, care shall not be 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 needs of the beneficiary. (MHSUDS IN 19-026)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures.

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
E.	**SURVEY ONLY** 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. 1) 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. 2) A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented. 3) 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. (MHSUDS IN 19-026)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures.

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
F.	**SURVEY ONLY** 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. 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. 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. (MHSUDS IN 19-026)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures.

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
G.	**SURVEY ONLY** 1) MHPs must establish and implement policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS a. MHPs may not require prior authorization for the following services/service activities: i. Crisis Intervention; ii. Crisis Stabilization; iii. Mental Health Services -; iv. Targeted Case Management; v. Intensive Care Coordination; and, vi. Medication Support Services. b. Prior authorization or MHP referral is required for the following services: i. Intensive Home-Based Services ii. Day Treatment Intensive iii. Day Rehabilitation iv. Therapeutic Behavioral Services v. Therapeutic Foster Care (MHSUDS IN 19-026)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures.

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	SURVEY ONLY 2) 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. (MHSUDS IN 19-026)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures.
	3) 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)).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures. • The MHP may extend the 72- hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the MHP justifies (to DHCS upon request) a need for additional information and how the extension is in the interest of the beneficiary. (42 C.F.R. § 438.210(d)(2))

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
H.	The MHP referral or prior authorization shall specify the amount, scope, and duration of treatment that the MHP has authorized. (MHSUDS IN 19-026)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures. • Review authorization approvals.
I.	**SURVEY ONLY** 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: o Retroactive Medi-Cal eligibility determinations; o Inaccuracies in the Medi-Cal Eligibility Data System; o Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dually-eligible beneficiaries; and/or, o Beneficiary's failure to identify payer (e.g., for inpatient psychiatric hospital services). (MHSUDS IN 19-026)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures.

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
J.	**SURVEY ONLY** 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. (MHSUDS IN 19-026)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of Authorization Requests ☐ Other evidence deemed appropriate by review team **GUIDANCE:** Review policies and procedures.

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
III.	***Presumptive Transfer***			
A.	The MHP shall have a comprehensive policy and procedure describing its process for timely provision of services to children and youth subject to Presumptive Transfer. (MHSUDS IN No., 17-032 and 18-027)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP's policies and procedures comply with the requirements of MHSUDS IN No. 17-032 • Review evidence the MHP's policies and procedures do not delay timely provision of SMHS to the child
B.	Upon presumptive transfer, the mental health plan in the county in which the foster child resides shall assume responsibility for the authorization and provision of SMHS and payments for services. (Welf. & Inst. Code § 14717.1(f).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	If the MHP in the county of original jurisdiction has completed an assessment of needed services for the foster child, the MHP in the county in which the foster child resides shall accept that assessment. (Welf. & Inst. Code § 14717.1(f).)			**GUIDANCE:** • Review evidence the MHP assumes responsibility, as required, upon presumptive transfer. • The foster child transferred to the mental health plan in the county in which the foster child resides shall be considered part of the county of residence caseload for claiming purposes from the Behavioral Health Subaccount and the Behavioral Health Services Growth Special Account. • The MHP in the county in which the foster child resides may conduct additional assessments if the foster child's needs change or an updated assessment is needed to determine the child's needs and identify the needed treatment and services to address those needs. • Review evidence the MHP in the county of original jurisdiction sent relevant beneficiary records. • Review evidence the MHP, when the county of original jurisdiction, timely sends beneficiary records to the MHP who is the county of responsibility under Presumptive Transfer.
D.	1) The MHP shall provide evidence of a single point of contact or a unit with a dedicated phone number and/ or email address for the purpose of Presumptive Transfer. (MHSUDS IN No., 17-032)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Contact Information ☐ MHP Website

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	2) The MHP shall provide evidence the contact information is posted to its public website. (MHSUDS IN No., 17-032)			☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP has identified a single point of contact and telephone number and/or email address • Verify the contact information is posted publicly on the MHP's website
K.	The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services for children/youth presumptively transferred to the MHP's responsibility. (42 C.F.R. § 438.206(c)(1)(i).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Provider contract boilerplate ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP meets timely access standards for children/youth presumptively transferred to the MHP's responsibility.
L.	The MHP will demonstrate that when there is an exception to Presumptive Transfer and a waiver is in place, the MHP ensures access to services for foster care children placed outside the county of origin. (MHSUDS IN No., 17-032)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Log of presumptive transfer waivers ☐ Evidence services are provided

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
M.	In situations when a foster child or youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition, MHPs must provide SMHS immediately, and without prior authorization. (MHSUDS IN No., 18-027)			☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review authorization decisions for out-of-county services. • Review policies and procedures for providing out-of-plan services to beneficiaries placed out of county
N.	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; W&I Code § 14717.1(b).)			
O.	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. (Welf. & Inst. Code § 14717.1(d)(6).)			

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
IV.	***Notice of Adverse Benefit Determination (NOABD) Requirements***			
A.	The MHP must provide beneficiaries with a NOABD under the following circumstances: 1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.(42 C.F.R. § 438.400(b)(1)) 2) The reduction, suspension or termination of a previously authorized service. (42 C.F.R. § 438.400(b)(2)) 3) The denial, in whole or in part, of a payment for service. (42 C.F.R. § 438.400(b)(3))			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ NOABDs (sample parameters specified by DHCS) ☐ Tracking Mechanism ☐ Assessment Results ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review NOAs and NOABDs issued during the triennial review period. • Verify the MHP is issuing NOABDs in accordance with title 42 requirements.

SECTION E COVERAGE AND AUTHORIZATION OF SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	4) The failure to provide services in a timely manner. (42 C.F.R. § 438.400(b)(4)) 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)). 6) The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities. (42 C.F.R. § 438.400(b)(7)).			• The MHP must retain copies of all NOABDs issued to the beneficiaries in a centralized file accessible to the Department. • Ask the MHP how it monitors its network providers and subcontractors compliance with the NOABD requirements. • Review the results of assessment determinations and verify NOABDs were sent to beneficiaries with an adverse benefit determination. • Review evidence of referrals to MCPs and verify NOABDs were sent to beneficiaries referred to MCPs for mental health services. • Review the MHP's grievance and appeal log and verify NOABDs were sent to beneficiaries when the MHP failed to meet timelines for resolution of grievances and appeals. • Review the MHP's timeliness data and EQRO report and verify that NOABDs were sent to beneficiaries when the MHP failed to provide service in a timely manner.

B.	The MHP includes the following information in the NOABD: 1. The adverse benefit determination of the MHP has made or intends to make. (42 C.F.R. § 438.404(b)(1)). 2. The reason for the adverse benefit determination. (42 C.F.R. § 438.404(b)(2). 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)). 4. 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 fair hearing after receiving notice that the adverse benefit determination is upheld. (42 C.F.R. § 438.404(b)(3)-(b)(4)). 5. The circumstances under which an appeal process can be expedited and how to request it. (42 C.F.R. § 438.404(b)(5)). 6. The beneficiary's right to have benefits continue pending resolution of the			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample NOABDs ☐ Other evidence deemed appropriate by review team **GUIDANCE (applies to questions 5a-5e):** • Review NOAs and NOABDs issued during the triennial review period. • Verify the MHP is issuing NOABDs in accordance with title 42 requirements and MHSUDS Information Notice 18-010E.

	CRITERIA	FINDING Y	N	INSTRUCTIONS TO REVIEWERS
	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)).			
V.	***Second Opinions***			
A.	The MHP provides a second opinion from a network provider, or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary. (MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b)).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of second opinion requests and determinations ☐ Second opinion tracking documentation ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review documentation of second opinion requests and determinations. Ask the MHP to show you at least 2 examples of such a request being made, including initial request and the documented outcome. • MHP network includes individual, group, and organizational providers.
B.	At the request of the beneficiary when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (MHP Contract, Ex. A, Att.2; CCR, title 9, § 1810.405(e)).			

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
VI.	***Judicial Council Forms***			
A.	The MHP maintains policies and procedures ensuring an appropriate process for the management of Forms JV 220, JV 220(A), JV 221, JV 222, and JV 223 and that related requirements are met. (Judicial Council Forms, JV 219)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Sample of JV220 (series) forms in beneficiary medical records **GUIDANCE:** • Use of the forms is optional for a child who is a ward of the juvenile court and living in an out-of-home facility that is not considered a foster care placement as defined in *Welfare and Institutions Code* Section 727.4, unless one of the forms is required by a local rule of court. • Use of the forms is not required if the court has previously entered an order giving the child's parent the authority to approve or deny the administration of psychotropic medication to the child. • The JV220 does not replace the need for a medication consent form to be completed. A physician could review with the beneficiary the elements in the JV220 that are some of the elements required to be covered as part of the medication consent form but medication consent needs to be completed and signed. The consent could document that the JV220 information was reviewed with the beneficiary and the JV220 could be attached to the medication consent form. • Review evidence the MHP tracks JV 220 requirements and documents.

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
I.	***Grievance and Appeal System Requirements***			
A.	The MHP shall have a grievance and appeal system in place for beneficiaries. (42 C.F.R. §§ 438.228(a), 438.402(a); Cal. Code Regs., tit. 9, § 1850.205.) 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: 1) A grievance process; 2) An appeal process; and, 3) An expedited appeal process. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(b)(1)-(b)(3).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary handbook ☐ Problem Resolution Informing Materials ☐ Problem Resolution forms ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • "Grievance" means an expression of dissatisfaction about any matter other than adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary's rights regardless of whether remedial action is requested. Grievance includes a beneficiary's right to dispute an extension of time proposed by the Contractor to make an authorization decision. (42 C.F.R. § 438.400) • A beneficiary may file a grievance either orally or in writing, at any time. • Following the receipt of a NOABD by the MHP, a beneficiary has 60 calendar days from the date on the NOABD in which to file a request for an appeal.
B.	The MHP shall ensure that each beneficiary has adequate information about the MHP's problem resolution processes by taking at least the following actions: 1) Including information describing the grievance, appeal, and expedited appeal processes in the MHP's beneficiary handbook and providing the beneficiary handbook to beneficiaries.			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	(MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(1)(A).) 2) Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all Contractor 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 fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of adverse benefit determination. For the purposes of this Section, a Contractor provider site means any office or facility owned or operated by the Contractor or a provider contracting with the Contractor at which beneficiaries may obtain specialty mental health services. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, §§ 1850.205(c)(1)(B) and 1850.210.) 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			• A beneficiary may request and appeal either orally or in writing. Further, unless the beneficiary requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. • Review evidence that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal). • CCR, title 9, chapter 11, section 1850.208 (a)(b) The expedited appeal process must, at a minimum: (a) 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, health or ability to attain, maintain, or regain maximum function. (b) Allow the beneficiary to file the request for an expedited appeal orally without requiring that the request be followed by a written appeal. • MHP to resolve and notify within 72 hours after receipt of expedited appeal. • Verify the MHP only has one level of appeal. • Review MHP's definitions of grievances and appeals for consistency with 42 C.F.R. 438.400(b)

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	network provider sites without having to make a verbal or written request to anyone. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(1)(C).) 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; 42 C.F.R. § 438.406(a); 42 C.F.R. § 438.228(a).)			
C.	The MHP shall allow beneficiaries to file grievances and request appeals. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(c)(1).)			
D.	The MHP shall have only one level of appeal for beneficiaries. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a).)			
E.	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; 42 C.F.R. § 438.406(b)(1).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Grievances, Appeals, and Expedited Appeals ☐ Grievance, Appeals, Expedited Appeals Log(s)

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	2) The acknowledgment letter shall include the following: a) Date of receipt b) Name of representative to contact c) Telephone number of contact representative d) Address of Contractor (MHSUDS IN No. 18-010E)			☐ Acknowledgement letter template ☐ Disposition letter template ☐ Sample notification letters ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures. • Verify acknowledgement letters are sent to beneficiaries in accordance with MHSUDS IN 18-010E. • The MHP is not required to send an acknowledgement letter for exempt grievances. (MHSUDS IN 18-010E)
	3) The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS IN 18-010E)			
F.	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 fair hearing. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(c)(1)(i)-(ii); Cal. Code Regs., tit. 9, § 1850.205(c)(2).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures.
G.	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. (MHP Contract, Ex. A, Att. 12)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • If the individual identified by the MHP is the person providing specialty mental health services to the beneficiary requesting

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
				assistance, the MHP shall identify another individual to assist that beneficiary. (Cal. Code Regs., tit. 9, § 1850.205(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).)
H.	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; Cal. Code Regs., tit. 9, § 1850.205(c)(5).)			
I.	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; Cal. Code Regs., tit. 9, § 1850.205(c)(6).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures
J.	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 Contractor's operations. The MHP shall consider these issues in the MHP's Quality Improvement Program, as required by Cal. Code Regs., tit. 9, §1810.440(a)(5). (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(7).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
K.	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; 42 C.F.R. § 438.406(b)(2)(i); 42 C.F.R. § 438.228(a).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures
L.	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; 42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures
M.	The MHP shall provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. 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. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(4).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures

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CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
N.	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; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures
O.	The MHP shall provide the beneficiary and his or her representative the beneficiary's case file, including medical records, 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. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(5).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures
P.	The MHP shall provide the beneficiary and his or her representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.408(b)-(c).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policies and procedures
Q.	The MHP shall treat oral inquiries seeking to appeal an adverse benefit determination as appeals (to establish the earliest possible filing date for the appeal) and must confirm these oral inquiries in writing, unless the beneficiary or the provider requests expedited resolution. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(3).)			

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
II.	***Handling Grievance and Appeals***			
A.	The MHP shall adhere to the following record keeping, monitoring, and review requirements: 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); Cal. Code Regs., tit. 9, § 1850.205(d)(1).)			**SUGGESTED DOCUMENTATION:** ☐ Grievance, Appeals, Expedited Appeals ☐ Grievance, Appeals, Expedited Appeals Log(s) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review logs to determine if required elements are logged • Review a sample of grievances, appeals, and/or expedited appeals; review sample of any expedited appeals received. • Verify information is present for each grievance, appeal and expedited appeal. • Examples of reviews and review meetings include, but are not limited to: ○ MHP Grievance Coordinator reviews the grievance/appeal documentation ○ MHP Grievance Coordinator meets with subject of the grievance ○ MHP Grievance Coordinator meets with subject's clinical supervisor
	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).)			

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CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
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. (Cal. Code Regs., tit. 9, § 1850.205(d)(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. (Cal. Code Regs., tit. 9, § 1850.205(d)(3).)			
5) Identify in its grievance, appeal, and expedited appeal documentation, the roles and responsibilities of the MHP, the provider, and the beneficiary. (Cal. Code Regs., tit. 9, § 1850.205(d)(5).)			

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	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. (Cal. Code Regs., tit. 9, § 1850.205(d)(6).)			
B.	*The MHP submits to DHCS a report that summarizes grievances, appeals and expedited appeals filed from 7/1 of the previous year through 6/30 of that year by October 1 of each year. (CCR, title 9, section 1810.375(a)).*			**SUGGESTED DOCUMENTATION:** ☐ Grievance, Appeals, Expedited Appeals Log(s) ☐ Annual Beneficiary Grievance and Appeal Report(s) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP is required to submit an annual report that summarizes beneficiary grievances, appeals, and expedited appeals received during the fiscal year. • The report must include the total number of grievances, appeals, and expedited appeals by type, subject areas, and disposition. • The information included in the Grievance and Appeal Log is consistent with that included in the annual report of grievances, appeals, and expedited appeals submitted to the Department each October 1.

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
III.	***Grievance Process***			
A.	The MHP's grievance process shall, at a minimum: 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) and (c)(3)(i).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Grievances ☐ Grievance, Appeals, Expedited Appeals Log(s) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review logs and sample grievances to verify the MHP is meeting established timeframes for resolving grievances, appeals, and expedited appeals. • The MHP may extend the timeframe for processing a grievance by up to 14 calendar days if the beneficiary requests an extension, or if the MHP determines that there is a need for additional information and that the delay is in the beneficiary's interest. (42 C.F.R. § 438.408(c)(1)(i)-(ii).) • If the MHP extends the timeframe, the Contractor shall, for any extension not requested by the beneficiary, make reasonable efforts to give the beneficiary prompt oral notice of the delay and give the beneficiary written notice of the extension and the reasons for the extension within 2 calendar days of the decision to extend the timeframe. • MHP's written notice of extension shall inform the beneficiary of the right to file a grievance if they disagrees with the MHP's decision (42 C.F.R. § 438.408(c)(2)(i)-(ii).) • The written notice of the extension is not a Notice of Adverse Benefit Determination. (Cal. Code Regs., tit. 9, § 1810.230.5.)
B.	Resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance. (42 C.F.R. § 438.408(a)-(b)(1).)			
C.	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 he or she could not be contacted. (Cal. Code Regs.,tit. 9, § 1850.206(c).)			
D.	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.)			
E.	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)			

	CRITERIA	FINDING Y	N	INSTRUCTIONS TO REVIEWERS
				• The Plan may extend the timeframe for an additional 14 calendar days if the beneficiary requests the extension or the Plan shows that there is a need for additional information and how the delay is in the beneficiary's best interest (Satisfaction of the DHCS, upon request)
IV.	***Appeals Process***			
A.	The MHP's appeal process shall, at a minimum: 1) Allow a beneficiary, or a provider or authorized representative acting on the beneficiary's behalf, to file an appeal orally or in writing. (42 C.F.R. § 438.402(c)(3)(ii).) 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).);			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Appeals and Expedited Appeals ☐ Grievance, Appeals, Expedited Appeals Log(s) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review logs and sample appeals and expedited appeals to verify the MHP is meeting established timeframes for resolving grievances, appeals, and expedited appeals. • The MHP shall ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals, and confirmed in writing unless the beneficiary or the provider requests expedited resolution. • The date the MHP receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes (42 C.F.R. § 438.406(b)(3).) • The MHP may extend the timeframe for processing an appeal by up to 14 calendar days, if the beneficiary requests an
	2) Require a beneficiary who makes an oral appeal that is not an expedited appeal, to subsequently submit a written, signed appeal. (42 C.F.R. § 438.402(c)(3)(ii).)			
	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.			

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	(42 C.F.R. § 438.408(a); 42 C.F.R. § 438.408(b)(2).)			extension or the MHP determines that there is a need for additional information and that the delay is in the beneficiary's interest. (42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2).) • If the MHP extends the timeframes, the MHP shall, for any extension not requested by the beneficiary, make reasonable efforts to give the beneficiary prompt oral notice of the delay and notify the beneficiary of the extension and the reasons for the extension in writing within 2 calendar days of the decision to extend the timeframe. • The MHP's written notice of extension shall inform the beneficiary of the right to file a grievance if he or she disagrees with the MHP's decision. • The MHP shall resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires (42 C.F.R. § 438.408(c)(2)(i)-(iii).) • The written notice of the extension is not a Notice of Adverse Benefit Determination. (Cal. Code Regs., tit. 9, §1810.230.5.);
	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 (42 C.F.R. § 438.406(b)(4).);			
	5) Provide the beneficiary and his or her 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).)			
	6) Provide the beneficiary and his or her representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for standard appeal resolutions.			

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

	CRITERIA	FINDING Y	N	INSTRUCTIONS TO REVIEWERS
	7) Allow the beneficiary, his or her 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).)			
B.	1) 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)).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Written notices of appeal resolution ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence that the MHP advised the beneficiary of the right to request a State fair hearing if the beneficiary is dissatisfied with the appeal decision. • MHPs must issue a written NAR (using DHCS template) to beneficiaries notifying them of the results of the appeal process. (MHSUDS IN 18-010E) • Verify the MHP is issuing the NAR "Your rights" document with the NAR.
	2) The MHP includes in the NAR the beneficiary's right to a State fair 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)).			
	3) The MHP includes in the written notice of the appeal resolution the beneficiary's right to request and receive benefits while the State fair hearing is pending, and how the beneficiary makes this request. (42 C.F.R. § 438.408(e)(2)(ii)).			

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	The MHP provides 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, title 9, § 1850.205(d)(6)).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Notification letter templates ☐ Sample written notices to providers ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Ask the MHP how its providers are notified of final disposition. Review evidence of provider notification. • Ask the MHP how it provides information about the grievance system to all providers and subcontractors.
D.	The MHP's expedited appeal process shall, at a minimum: 1) 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).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Expedited Appeals ☐ Grievance, Appeals, Expedited Appeals Log(s) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • "Expedited Appeal" is an appeal used when the mental health plan determines (for a request from the beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard 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.)
	2) 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).)			

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

	CRITERIA	FINDING Y	N	INSTRUCTIONS TO REVIEWERS
	3) 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).)			
	4) 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 Contractor must inform beneficiaries of this sufficiently in advance of the resolution timeframe for the expedited appeal. (42 CFR § 438.406(b)(4); 42 CFR § 438.408(b)-(c).)			
	5) 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 Contractor receives the appeal. (42 C.F.R. § 438.408(b)(3).)			
	6) 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 his or her 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. §			

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	438.408(d)(2); Cal. Code Regs., tit. 9, § 1850.207(h).)			
	7) If the MHP denies a request for an expedited appeal resolution, the MHP shall: a) Transfer the expedited appeal request to the timeframe for standard resolution of no longer than 30 calendar days from the day the Contractor receives the appeal. (42 C.F.R. § 438.410(c)(1).) b) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal.			
V.	***Continuation of Services***			
A.	The MHP must continue the beneficiary's benefits if all of the following occur: a) The beneficiary files the request of an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii); b) The appeal involves the termination, suspension, or reduction of previously authorized services;			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Documentation of continued services for beneficiaries pending appeals and/or State Fair Hearings ☐ Documentation of written notice to beneficiaries, if Aid Paid Pending (APP) criteria are met ☐ Other evidence deemed appropriate by review team

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	c) The services were ordered by an authorized provider; d) The period covered by the original authorization has not expired; and, e) The beneficiary timely files for continuation of benefits. (42 C.F.R. § 438.420(b).)			**GUIDANCE:** • Beneficiaries must have met APP criteria per CCR, title 22, section 51014.2 (i.e., beneficiary made a request for an appeal within 10 days of the date the NOABD was mailed or given to the beneficiary or, if the effective date of the change is more than 10 days from the NOABD date, before the effective date of the change).
B.	If, at the beneficiary's request, the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the following occurs: a) The beneficiary withdraws the appeal or request for a State Hearing; b) The beneficiary fails to request a State Hearing and continuation of benefits within 10 calendar days after the MHP sends the notice of adverse resolution (i.e., NAR) to the beneficiary's appeal; c) A State Hearing office issues a hearing decision adverse to the beneficiary. (42 C.F.R. § 438.420(c).)			

SECTION F BENEFICIARY RIGHTS AND PROTECTIONS

CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	If the MHP or the State Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MHP must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 C.F.R. § 438.424(a).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ State Hearing logs/results ☐ Evidence the MHP authorized or provided services to beneficiaries if the denial was reversed ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's policy and procedure • Review evidence the MHP authorized or provided services within the required timeframes.

SECTION G PROGRAM INTEGRITY

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
I.	***Compliance Program***			
A.	The MHP has a Compliance program designed to detect and prevent fraud, waste and abuse. (C.F.R. 42 § 455.1(a)(1) and C.F.R. 42 § 438.608).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Compliance Plan ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review MHP Compliance Plan
B.	The MHP Compliance program includes: 1) 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).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Compliance Plan ☐ Standards of Conduct ☐ Acknowledgement form signed by employees ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review MHP written administrative and management policies and procedures, and standards of conduct.

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CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	2) A Compliance Officer (CO) who is responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the contract and who reports directly to the MHP Director. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(1).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Organizational Chart ☐ Duty Statement of Compliance Officer ☐ Compliance Plan ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the compliance officer is accountable to senior management. • If the Compliance Officer reports to Agency Director, ask MHP how the Compliance officer works with the MHP staff to fulfill obligations. What is the communication process?

SECTION G PROGRAM INTEGRITY

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	3) A Regulatory Compliance Committee (RCC) at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements of this contract. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. §438.608(a)(1).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Compliance Plan ☐ Organizational Chart ☐ RCC agendas, minutes, roster ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the compliance committee is accountable to senior management. • Review meeting minutes to determine trends and issues addressed by the RCC.

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	4) A system for training and education for the 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).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Evidence of completed training ☐ Training Plan ☐ Training curriculum ☐ Duty Statement of Compliance Officer ☐ Tracking mechanism (e.g., log) to ensure all staff and contractors complete training ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence of specialized training and education for compliance officer. • Review evidence of policies identifying training and educational requirements for the compliance officer. • Review evidence the MHP is tracking completion of required training. • Review training plan.
	5) Effective lines of communication between the CO and the organization's employees. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. §438.608(a)(1).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Compliance Plan ☐ Signage/Notices to staff ☐ Compliance training materials for staff ☐ Compliance Hotline

SECTION G PROGRAM INTEGRITY

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
				☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review examples of communication (i.e., newsletters; memos, postings, etc.).
	6) Enforcement of standards through well publicized disciplinary guidelines. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. §438.608(a)(1).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Compliance Plan ☐ Employee Acknowledgement of Receipt ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence of disciplinary guidelines and how MHP will enforce those standards.

SECTION G PROGRAM INTEGRITY

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	7) 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).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Compliance Plan ☐ Monitoring and auditing tools ☐ Monitoring and auditing results ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures to determine how the MHP defines "prompt response." • Review evidence of prompt response for detected offenses and corrective action plans. • Review evidence the MHP coordinates with law enforcement agencies for suspected criminal acts.

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
II.	***Fraud Reporting Requirements***			
A.	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: 1) Any potential fraud, waste, or abuse. (42 C.F.R. §438.608(a)(7).) 2) All overpayments identified or recovered, specifying the overpayments due to potential fraud. (42 C.F.R. §438.608(a), (a)(2).) 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).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Compliance Plan ☐ Monitoring and auditing tools ☐ Monitoring and auditing results ☐ Evidence of tracking of overpayments to providers ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures to determine how the MHP defines “prompt response.” • Review evidence of prompt response for detected offenses and corrective action plans. • Review evidence the MHP coordinates with law enforcement agencies for suspected criminal acts. • Review evidence the MHP monitors overpayments to providers. • Review the MHP policies and procedures on providing detailed information about the False Claims Act. • Review the MHP policies and procedures on provision for the Contractor’s suspension of payments.

SECTION G PROGRAM INTEGRITY

CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	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)			
C	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).)			

SECTION G PROGRAM INTEGRITY

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
D.	The MHP shall implement and maintain arrangements or procedures that include provision for the Contractor'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).)			
III.	***Service Verification Requirements***			
A.	The MHP implements and maintains procedures designed to detect fraud, waste and abuse that include provisions to verify services reimbursed by Medicaid were received by the beneficiary. (CCR 42 C.F.R. § 438.608(a)(5).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Tools for verifying services were furnished ☐ Evidence of service verification activities ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Refer to MHP Contract, Program Integrity Requirements. Pursuant to title 42, C.F.R., section 455.1(a)(2), the Contractor must have a way to verify with beneficiaries that services were actually provided. "Under authority of the sections 1902 (a)(4), 1903 (i)(2) and 1909 of the Social Security Act, Subpart A

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CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
				provides State plan requirements for the identification, investigation and referral of suspected fraud and abuse cases. In addition, the subpart requires the state have a method to verify whether services reimbursed by Medicaid were actually furnished to the *beneficiaries*. • MHP to provide documented evidence regarding their verification method, date of implementation, frequency, and sample size in accordance with this requirement. • MHP to provide documented evidence regarding their findings and actions taken. Review tracking documents or logs. • MHP to provide documented evidence that services reimbursed by Medicaid/Medi-Cal that were not received by the beneficiary were recouped. • MHP may determine service verification method. Examples of methodologies may include, but are not limited to: o Sending Evidence of Service letters to beneficiaries o Sign-in/sign-out sheets for group services o Call scripts/logs • When unable to verify services were furnished to beneficiaries, the MHP has a mechanism in place to ensure appropriate actions are taken.
IV.	***Disclosure Requirements***			

SECTION G PROGRAM INTEGRITY

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
A.	The MHP ensures collection of disclosures of ownership, control, and relationship information for persons who have an ownership or control interest in the MHP, if applicable, and ensures its subcontractors and network providers submit disclosures to the MHP regarding the network provider's (disclosing entities) ownership and control. (42 C.F.R. Section 455.101 and 104).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Provider contracts with reporting requirements ☐ Monitoring and tracking tools ☐ Provider disclosures ☐ MHP employee disclosures ☐ Results of monitoring activities ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review MHP verification of disclosure of ownership, control and relationship information from individual providers, agents, and managing employees. • The MHP is responsible to monitor and obtain the required information from their contracted providers, regardless of for-profit or non-profit status. • In the event that, in the future, any person obtains an interest of 5% or more of any mortgage, deed of trust, note or other obligation secured by Contractor, and that interest equals at least 5% of Contractor's property or assets, then the Contractor will make the disclosures set forth in subsection 2(a). • Review evidence the MHP requires providers, or any person with a 5 percent or more direct or indirect ownership interest in the provider to submit a set of fingerprints. • The MHP must terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and
B.	As a condition of enrollment, the MHP must require providers to consent to criminal background checks including fingerprinting when required to do so by DHCS or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider. (42 C.F.R. § 455.434(a).)			
D.	The MHP requires providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable. (42 C.F.R. § 455.434(b)(1) and (2)).			
E.	1) The MHP shall ensure that its subcontractors and network providers submit the disclosures below to the MHP regarding the network providers' (disclosing entities') ownership and control. The MHP's network providers must be required to submit updated disclosures to the MHP upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the			

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	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104. (MHP Contract, Ex. A, Att. 13)			accurate information and cooperate with any screening methods required in C.F.R., title 42, section 455.416. • Review evidence the MHP denies enrollment or terminates the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years
	2) Disclosures must include: a) The name and address of any person (individual or corporation) with an ownership or control interest in the network provider. b) The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address; c) Date of birth and Social Security Number (in the case of an individual); 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); e) Whether the person (individual or corporation) with an ownership or control interest in the Contractor's network provider is related to another person with ownership or control interest in the same			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Provider disclosures ☐ MHP employee disclosures ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review MHP verification of disclosure of ownership, control and relationship information from individual providers, agents, and managing employees.

CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
or any other network provider of the Contractor as a spouse, parent, child, or sibling; or 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; f) The name of any other disclosing entity in which the Contractor or subcontracting network provider has an ownership or control interest; and g) The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.			
3) 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.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Provider disclosures ☐ MHP employee disclosures ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review MHP verification of disclosure of ownership, control and relationship information from individual providers, agents, and managing employees.

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
				• For each provider in Contractor's provider network, Contractor shall provide the Department with all disclosures before entering into a network provider contract with the provider and annually thereafter and upon request from the Department during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104.
F.	The MHP must submit disclosures and updated disclosures to the Department or HHS including information regarding certain business transactions within 35 days, upon request. 1. The ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and 2. Any significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request. 3. The MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Disclosures ☐ Tracking log ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP requires and submits the required disclosures. • Review evidence the MHP monitors ownership and control of its subcontractors.

SECTION G PROGRAM INTEGRITY

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
G.	The MHP shall submit the following disclosures to DHCS regarding the MHP's management: 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).) 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.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Disclosures ☐ Tracking log ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review evidence the MHP requires and submits the required disclosures.
V.	***Database Check Requirements***			
A.	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: a) Social Security Administration's Death Master File. b) National Plan and Provider Enumeration System (NPPES)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Reports of database queries ☐ Tracking logs ☐ Contract with vendor to provide service ☐ Other evidence deemed appropriate by review team **GUIDANCE:**

SECTION G PROGRAM INTEGRITY

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	c) Office of the Inspector General List of Excluded Providers and Entities(LEIE) d) System of Award Management (SAM) e) Department's Medi-Cal Suspended and Ineligible List (S&I List). MHP Contract, Ex. A, Att. 13; 42 C.F.R. §§ 438.602(b)(d) and 455.436) 2) The MHP has a process to confirm monthly that no providers is on the: a) OIG List of Excluded Individuals/Entities (LEIE). b) System of Award Management (SAM) Excluded Parties List System (EPLS). c) DHCS Medi-Cal List of Suspended or Ineligible Providers (S&I List). (42 C.F.R. §§ 438.608(d), an 455.436)			• The Excluded Parties List System (EPLS) has been integrated into the System Award Management (SAM) database. • The MHP does not employ or contract with providers excluded from participation in Federal health care programs under C.F.R., title 42, section 1128 or section 1128A of the Social Security Act or C.F.R., title 42, section 438.214. • Verify the MHP is checking required databases: http://oig.hhs.gov/exclusions/exclusions_list.asp and https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp and https://www.sam.gov/portal/SAM/#1 • Verify frequency of monitoring efforts. Per 42 C.F.R. Section 455.436, MHPs are required to check the LEIE and SAM databases no less frequently than monthly. • The Social Security Death Master File is required to be checked upon enrollment. • The National Plan and Provider Enumeration System databases is required to be checked upon enrollment and re-enrollment (i.e., certification) of the provider. • Review the MHP written policies and procedures to ensure that the MHP is not employing or contracting with excluded providers and contractors. Verify that the MHP is following its written P&Ps.

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	3) If the MHP finds a party that is excluded, it must promptly notify DHCS. (42 C.F.R. §438.608(a)(2),(4).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Evidence of corrective action measures ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review policies and procedures regarding the identification of an excluded provider and action(s) taken by the MHP. • The MHP shall not certify or pay any excluded provider with Medi-Cal funds, and any such inappropriate payments or overpayments may be subject to recovery and/or be the basis for other sanctions by the appropriate authority.

SECTION G PROGRAM INTEGRITY

CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
VI.	***Provider Requirements***			
A.	The MHP ensures providers of services that require a license, registration or waiver maintain a current license, registration or waiver. (CCR, title 9, section 1840.314(d) and 42 C.F.R. Section 455.412).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Tracking logs ☐ Verification reports ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP to verify that providers are licensed in accordance with state law. • Review evidence the MHP confirms eligibility of registered providers. • Review the MHPs policies and procedures for submitting a Professional Licensing Waiver (PLW) request to DHCS.
B.	The MHP verifies all ordering, rendering and referring providers have a current National Provider Identification (NPI) number.(42 C.F.R. Section 455.440).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Tracking logs ☐ Verification reports ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP to verify that all ordering, referring and rendering providers, including contract providers, have a current NPI number

SECTION H OTHER REGULATORY AND CONTRACTUAL REQUIREMENTS

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
A.	*The MHP must comply with the requirements of W&I Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports.*			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Evidence of submission of annual cost report ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Verify the MHP submitted its most recent annual cost reports by December 31st • Verify the MHP sent a hard copy of its cost reports to DHCS
B.	1) The MHP, and subcontractors, shall allow the Department, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized designees, to evaluate Contractor's, and subcontractors', performance under this contract, including the quality, appropriateness, and timeliness of services provided, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor and its subcontractors pertaining to such services at any time. (MHP Contract, Ex. E; 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Records and documents include, but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries.

	2) The MHP shall allow such inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (MHP Contract, Ex. E; 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii).)			

SECTION I CHART REVIEW—NON-HOSPITAL SERVICES

PLEASE NOTE: CHART REVIEW PROTOCOL ITEMS WILL BE REVIEWED FOR EACH CHART IDENTIFIED IN THE SAMPLE.

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
I.	***Medical Necessity***			
A.	The beneficiary must meet medical necessity criteria outlined in subsections (1-3) to be eligible for services. (CCR, title 9, § 1830.205(b).) 1) The beneficiary meets DSM criteria for an included ICD diagnosis for outpatient SMHS in accordance with the MHP contract. (MHSUDS IN Nos., 15-030, 16-016, 16-051, and 17-004E).			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review assessment(s) documentation to support A1-3. • Review Assessment documentation to ensure DSM diagnostic criteria are met. • Ensure the beneficiary's diagnosis is on the list of included outpatient diagnoses in MHSUDS IN Nos., 16-051 and 17-004E and CCR, title 9, chapter 11, section 1830.205

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	2) The beneficiary must have at least one of the following impairments as a result of the mental disorder or emotional disturbance (listed above in A1): 1. A significant impairment in an important area of functioning. 2. A probability of significant deterioration in an important area of life functioning. 3. A probability that the child will not progress developmentally as individually appropriate 4. For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate. (CCR, title 9, § 1830.205 (b)(2)(A-C).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Refer to CCR, title 9, §§ 1830.205 (b)(2)(A-C) and 1830.210. • Review Assessment documentation in each [sampled] beneficiary's medical record.

CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
3) The proposed and actual intervention(s) meet the intervention criteria listed below: a) The focus of the proposed and actual intervention(s) addresses the condition identified in No. 1b (1-3)above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that the SMHS can correct or ameliorate per No. 1 (b)(4). (CCR, title 9, § 1830.205(b) (3)(A).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • The proposed interventions (found on client plan) and the actual intervention(s) (found in progress note documentation) must focus on the condition(s) identified in No. A2 (1-3) or, for full-scope MC beneficiaries under the age of 21 years, on a condition that SMHS can correct or ameliorate per No.A2 (4).
b) The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (A, B, C, or D): A. Significantly diminish the impairment. B. Prevent significant deterioration in an important area of life functioning. C. Allow the child to progress developmentally as individually appropriate. D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition. (CCR, title 9, § 1830.205 (b)(3)(B)(1-4).)			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	The condition would not be responsive to physical health care based treatment. (CCR, title 9, § 1830.205(b)(3)(C).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Disorders due to medical conditions are not covered. Examples include, but are not limited to: o Psychosis due to Wilson's disease o Depression due to hypothyroidism
II.	***Assessments***			
A.	The MHP must establish written standards for (1) timeliness and (2) frequency of the Assessment documentation. (MHP Contract, Ex. A, Att. 9)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's written documentation standards guidelines. • Review medical records to verify the following: o Assessments are completed in accordance with MHP's established written documentation standards for timeliness. o Assessments are completed in accordance with MHP's established written documentation standards for frequency. Note: Does not apply to Initial Assessment.

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	The MHP shall ensure the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed (MHP Contract, Ex. A, Att. 9; CCR, title 9, §§ 1810.204 and 1840.112): 1) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review for the required appropriate elements. • The Assessment should address history of trauma and exposure to trauma, as applicable. • The Assessment should, if possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports. • Risk in this context refers to triggers and/or situations (e.g., psychosocial factors) which may present a risk of decompensation and/or escalation of the beneficiary's condition. • A history of Danger-To-Self (DTS) or Danger-To-Others (DTO), are examples of "risks" that are to be evaluated as part of the assessment. Additional examples are previous inpatient hospitalizations for DTS or DTO; prior suicide attempts; lack of family or other support systems; prior arrests; currently on probation; history of alcohol/drug abuse; history of trauma or victimization; history of self-harm behaviors, e.g., cutting; history of assaultive behavior; physical impairment which
	2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health including, as applicable; living situation, daily activities, social support, and cultural and linguistic factors.			
	3) History of trauma or exposure to trauma.			
	4) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions.			

CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
5) Medical History, including: a) Relevant physical health conditions reported by the beneficiary or a significant support person. b) Name and address of current source of medical treatment. c) For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history.			makes him/her vulnerable to others, e.g., limited vision, deaf, wheelchair bound. • The diagnosis, 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; or who is waivered, or registered, and under the direction of a LMHP. • MHP may designate certain other qualified providers to contribute to the assessment and bill for time spent on assessment activities, 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; State Plan, Section 3, Supplement 3 to Attachment 3.1-A, pg. 2m-p). • The Assessment elements should be integrated (e.g., a case conceptualization) in order for the LMHP to formulate a diagnosis which meets DSM criteria.
6) Medications, including: a) Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration and medical treatment. b) Documentation of the absence or presence of allergies or adverse reactions to medications. c) Documentation of informed consent for medications.			
7) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs.			
8) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to their mental health needs and functional impairment(s).			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	9) Risks. Situations that present a risk to the beneficiary and others, including past or current trauma.			
	10) Mental Status Examination			
	11) A Complete Diagnosis. A diagnosis from the current ICD-code that is consistent with the presenting problems, history, mental status exam and/or other clinical data; including any current medical diagnosis.			
C.	All entries in the beneficiary record (i.e., Assessments) include: 1) Date of service. 2) The signature of the person providing the service (or electronic equivalent); 3) The person's type of professional degree, licensure or job title. 4) Relevant identification number (e.g., NPI number), if applicable. 5) The date the documentation was entered in the medical record. (MHP Contract, Ex. A, Att. 9)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review documentation for the required elements.

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
III.	***Medication Requirements***			
A.	The provider obtains and retains a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication. (MHP Contract, Ex. A, Att. 9)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the medication orders and medication consents. • It is acceptable for the medication consent to include attestations, signed by the provider and the beneficiary, that the provider discussed each of the required components of the medication consent with the beneficiary. • The use of check boxes on the medication consent form indicating the provider discussed the need for medication and potential side effects is acceptable as long as the information is included in accompanying written materials provided to the beneficiary. • An alternative treatment is a treatment other than/in addition to the use of medication. • JV (court order) documents are acceptable forms of medication consent, in addition to ensuring all elements are captured in the consent. • Medication consents should be specific for each medication prescribed. • More than one medication can be on a medication consent form.

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	Written medication consents shall include, but not be limited to, the following required elements (MHP Contract, Ex. A, Att. 9): 1) The reasons for taking such medications.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the medication orders and medication consents. • It is acceptable for the medication consent to include attestations, signed by the provider and the beneficiary, that the provider discussed each of the required components of the medication consent with the beneficiary. • The use of check boxes on the medication consent form indicating the provider discussed the need for medication and potential side effects is acceptable as long as the information is included in accompanying written materials provided to the beneficiary. • An alternative treatment is a treatment other than/in addition to the use of medication. • JV (court order) documents are acceptable forms of medication consent, in addition to ensuring all elements are captured in the consent. • Medication consents should be specific for each medication prescribed. • More than one medication can be on a medication consent form.
	2) Reasonable alternative treatments available, if any.			
	3) Type of medication.			
	4) Range of frequency (of administration).			
	5) Dosage.			
	6) Method of administration.			
	7) Duration of taking the medication.			
	8) Probable side effects.			
	9) Possible side effects if taken longer than 3 months.			
	10) Consent, once given, may be withdrawn at any time.			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	All entries in the beneficiary record (i.e., Medication Consents) include: 1) Date of service. 2) The signature of the person providing the service (or electronic equivalent); 3) The person's type of professional degree, licensure or job title. 4) Relevant identification number (e.g., NPI number), if applicable. 5) The date the documentation was entered in the medical record. (MHP Contract, Ex. A, Att. 9)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review documentation for the required elements.
D.	The MHP shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be: 1) Under the supervision of a person licensed to prescribe or dispense medication. 2) Performed at least annually. 3) Inclusive of medications prescribed to adults and youth. (MHP Contract, Ex. A, Att. 5)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Prescribing practice guidelines ☐ Monitoring tools ☐ Monitoring results ☐ Training protocols ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • The monitoring mechanism must be under the supervision of a person licensed to prescribe or dispense prescription drugs. • Review the policy to determine if it specifically addresses monitoring psychotropic medication use for children / youth. • Review evidence of psychotropic medication monitoring by the MHP.

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
				• Review evidence of corrective actions taken to address quality of care concerns related to psychotropic medication use.
IV.	***Client Plans***			
A.	1) Services shall be provided, in accordance with the State Plan, to beneficiaries, who meet medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan. (MHP Contract, Ex. A, Att 2)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Services shall be provided in an amount, duration, and scope as specified in the individualized Client Plan for each beneficiary. • Review medical records to verify the proposed interventions on the Client Plan for each beneficiary are based on the beneficiary's need for services and sufficient in amount, duration and scope.
	2) The MHP shall ensure that all medically necessary SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. (MHP Contract, Ex. A, Att 2)			
B.	The client plan has been updated at least annually and/or when there are significant changes in the beneficiary's condition.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's written documentation standards guidelines. • Review the prior and current client plans for timeliness and frequency.

SECTION I CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	The MHP shall ensure that Client Plans: 1) Have specific, observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairment as a result of the mental health diagnosis.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the client plans to verify compliance with requirements specified in the MHP contract. • Assessment, Crisis Intervention, Plan Development, Medication Support for the purposes of assessment and plan development or if an urgent need exists, TCM for the purposes of linkage and referral, plan development and assessment; and Crisis Stabilization services may be provided prior to completion of the client plan. • If MHP does not set its own timeliness standard, initial client plans should be completed within 60 days. • The client plan is to be a collaborative process with the beneficiary. • A detailed description of the intervention should include the treatment category (e.g., TCM, therapy, etc.) and a description of specific strategies (i.e., what is being done) within the identified modality and how these strategies address the beneficiary's functional impairment.
	2) Identify the proposed type(s) of interventions or modality, including a detailed description of the intervention to be provided.			
	3) Have a proposed frequency of the intervention(s).			
	4) Have a proposed duration of intervention(s).			
	5) Have interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.			
	6) Have interventions are consistent with client plan goal(s)/treatment objective(s).			
	7) Have interventions are consistent with the qualifying diagnoses.			
D.	1) The MHP shall ensure that Client Plans are signed (or electronic equivalent) by: i. The person providing the service(s) or, ii. A person representing a team or program providing the service(s) or,			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records

CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
iii. A person representing the MHP providing service(s). (CCR, title 9, § 1810.440(c).) 2) Services (i.e., Plan Development) shall be provided within the scope of practice of the person delivering service, if professional licensure is required for the service. Services shall be provided under the direction of one or more of the following: A. Physician B. Psychologist C. Licensed Clinical Social Worker D. Licensed Marriage and Family Therapist E. Licensed Professional Clinical Counselor F. Registered Nurse, including but not limited to nurse practitioners, and clinical nurse specialists G. Waivered/Registered Professional when supervised by a licensed mental health professional in accordance with laws and regulations governing the registration or waiver.			☐ MHP's operational definition of direction ☐ MHP's scope of practice policies ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • MHP must provide a list of all licensed and unlicensed (waivered/registered) providers, providers' signature (or electronic equivalent), professional degree, and licensure or job title. • "Other qualified providers" must meet MHP's minimum qualifications • See Board of Behavioral Sciences and Board of Psychology for scope of practice and supervision requirements. • Services shall be provided under the direction of a waivered/registered professional when supervised by a licensed professional under the authority of their respective licensing board. • Direction may include, but is not limited to, being the person directly providing the service, acting as a clinical team leader, direct or functional supervision, or approval of client plans. • Individuals are not required to be physically present at the service site to exercise direction.

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	(CCR, title 9, § 1840.314(e); 1810.440(c); State Plan, Supplement 3, Attachment 3.1-A, pp. 2m-p; MHSUDS IN No. 17-040) 3) The Client Plan must be co-signed by the LMHP directing services, within their scope of practice under State law, if the individual providing services must be under the direction of an LMHP (from the categories above). (CCR, title 9, § 1840.314(e); 1810.440(c); State Plan, Supplement 3, Attachment 3.1-A, pp. 2m-p; MHSUDS IN No. 17-040)			
E.	1) The MHP shall ensure that Client Plans include documentation of the beneficiary's participation in and agreement with the Client Plan. (MHP Contract, Ex. A, Att. 9; CCR, title 9, § 1810(c)(2).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Definition of long-term care beneficiary

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	2) The MHP shall ensure that Client Plans include the beneficiary's signature or the signature of the beneficiary's legal representative when: a) The beneficiary is expected to be in long-term treatment, as determined by the MHP, and, b) The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS. (CCR, title 9, § 1810.440(c)(2)(A).)			☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review for the beneficiary's degree of participation and agreement with the plan as follows: o Reference the beneficiary's participation and agreement in the body of the client plan, the beneficiary's signature on the client plan, or a description of the beneficiary's participation and agreement in the medical record. • The beneficiary signature is required under the following circumstances: o The beneficiary expected to be in long-term treatment as determined by the MHP. o The beneficiary is receiving more than one SMHS.(e.g., Individual therapy and TCM) • The beneficiary is required to sign the client plan per the MHP's documentation standards guidelines. • Review evidence that, when the beneficiary's signature is required on the client plan and the beneficiary refuses or is unavailable for signature, there is a written explanation of the refusal or unavailability. • Review the MHP's definition of a long-term care beneficiary.
	2) When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan includes a written explanation of the refusal or unavailability of the signature. (CCR, title 9, § 1810.440(c)(2)(B).)			
F.	The MHP shall have a written definition of what constitutes a long-term care beneficiary. (MHP Contract, Ex. A, Att. 9)			
G.	There is documentation in the Client Plan that a copy of the Client Plan was offered to the beneficiary.			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
H.	All entries in the beneficiary record (i.e., Client Plans) include: 1) Date of service. 2) The signature of the person providing the service (or electronic equivalent); 3) The person's type of professional degree, licensure or job title. 4) Relevant identification number (e.g., NPI number), if applicable. 5) The date the documentation was entered in the medical record. (MHP Contract, Ex. A, Att. 9)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review documentation for the required elements.
V.	***Progress Notes***			
A.	The MHP shall ensure that progress notes describe how services provided reduced the impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. (MHP Contract, Ex. A, Att. 9)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's documentation standards guidelines. • The MHP sets its timeliness standards for documentation. • The date the service was documented in the medical record by the person providing the service.
B.	Items that shall be contained in the client record (i.e., Progress Notes) related to the beneficiary's progress in treatment include all of the following: 1) Timely documentation of relevant aspects of client care, including documentation of medical necessity.			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions.			• Time taken to provide the services may include travel and documentation time. • Actual interventions must be on the current client plan.
	3) Interventions applied, beneficiary's response to the interventions, and the location of the interventions.			
	4) The date the services were provided.			
	5) Documentation of referrals to community resources and other agencies, when appropriate.			
	6) Documentation of follow-up care or, as appropriate, a discharge summary.			
	7) The amount of time taken to provide services.			
	8) The following: a) The signature of the person providing the service (or electronic equivalent); b) The person's type of professional degree, and, c) Licensure or job title.			
C.	When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include: 1) Documentation of each person's involvement in the context of the mental health needs of the beneficiary.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:**

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	2) The exact number of minutes used by persons providing the service. 3) Signature(s) of person(s) providing the services. (CCR, title 9, § 1840.314(c).)			• Review the MHP's documentation standards guidelines. • Review progress notes for compliance.
D.	Progress notes shall be documented at the frequency by types of service indicated below: 1) Every service contact for: A. Mental health services B. Medication support services C. Crisis intervention D. Targeted Case Management E. Intensive Care Coordination F. Intensive Home Based Services G. Therapeutic Behavioral Services 2) Daily for: A. Crisis residential B. Crisis stabilization (one per 23/hour period) C. Day treatment intensive D. Therapeutic Foster Care 3) Weekly for: A. Day treatment intensive (clinical summary) B. Day rehabilitation C. Adult residential (MHP Contract, Ex. A, Att. 9; CCR, title 9, §§ 1840.316(a)-(b); 1840.318 (a-b), 1840.320(a-b).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • The day treatment intensive weekly clinical summary note must be reviewed and signed by one of the following: ○ Physician ○ Licensed/Registered/Waivered Psychologist ○ Licensed/Registered/Waivered Social Worker ○ Licensed/Registered/Waivered Marriage and Family Therapist ○ Licensed/Registered/Waivered Professional Clinical Counselor ○ Registered Nurse • Documentation must support the program requirements, the type of service, date of service, and units of time claimed.

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
E.	All entries in the beneficiary record (i.e., Client Plans) include: 1) Date of service. 2) The signature of the person providing the service (or electronic equivalent); 3) The person's type of professional degree, licensure or job title. 4) Relevant identification number (e.g., NPI number), if applicable. 5) The date the documentation was entered in the medical record. (MHP Contract, Ex. A, Att. 9)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review documentation for the required elements.
VI.	***Provision of ICC and IHBS to Children and Youth***			
A.	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 Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ ICC/IHBS service criteria ☐ List of beneficiaries receiving ICC/IHBS ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review medical records of children/youth in the sample to verify compliance. • The ICC Coordinator and the CFT should reassess the strengths and needs of children and youth and their families, at least every 90 days, and as needed.
B.	The ICC Coordinator and the CFT should reassess the strengths and needs of children and youth, and their families, at least every 90 days, and as needed. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
				• Intervention strategies should be continually monitored, so that modifications can be made based on results. • The ICC coordinator conducts referral, linkages, monitoring and follow-up activities, to ensure that the child's/youth's needs are met. This includes ensuring that services are being furnished in accordance with the child's/youth's plan, and that services are adequate to meet the child's/youth's needs. • The ICC coordinator makes recommendations to the CFT members regarding the necessary changes to the client plan, and works with the CFT and other providers to make these adjustments.
C.	Claims for ICC must use the following: 1) Procedure code T1017 2) Procedure modifier "HK" 3) Mode of service 15 4) Service function code 07 (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ ICC and IHBS claim lines ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review claim lines for ICC and IHBS services. • Participation in the CFT meeting is claimed as ICC. • Time claimed, which may include active listening time, must be supported by documentation showing what information was shared, and how it can/will be used in providing, planning, or coordinating services to the client (i.e., how the information discussed will impact the client plan). • Each participating provider in a CFT meeting may bill for the total number of minutes during which a client(s) with whom that provider has a client/provider relationship is discussed.
D.	Claims for IHBS must use the following: 1) Procedure code H2015 2) Procedure modifier "HK" 3) Mode of service 15 4) Service function code 57 (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			• Such a provider may claim for minutes during which one of their clients is being discussed, up to the length of the meeting. • When multiple providers are participating in a CFT meeting, and each provider's participation is appropriately documented for the amount of time claimed, the total number of all the provider's minutes claimed may exceed the length of the meeting.
E.	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). (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)			
VII.	***Provision of Linguistically Competent Services***			
A.	There any evidence that mental health interpreter services are offered and provided, when applicable.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review CCPR, MHP's policies and procedures and medical records for: • If beneficiary is Limited English Proficient (LEP), there is documentation interpreter services were offered and provided and an indication of the beneficiary's response.
B.	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.			
C.	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; 42 C.F.R. § 438.10(d).)			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
D.	When applicable, treatment specific information was provided to beneficiaries in an alternative format (e.g., braille, audio, large print, etc.). (CCR, title 9, § 1810.410(e)(2), and 3200.210)			• There is evidence beneficiaries are made aware that SMHS are available in their preferred language. • Linkages might include referrals to community based organizations or other community resources. • Interpreter services mean oral and sign language. • When applicable, review evidence beneficiaries were provided with information in an alternative format.
VIII.	***Provision of Day Treatment Intensive and Day Rehabilitation Services***			
A.	Day Treatment Intensive and Day Rehabilitation programs include all the following required service components: A. Daily Community Meetings; * B. Process Groups; C. Skill-building Groups; and D. Adjunctive Therapies; E. Additionally, Day Treatment Intensive programs also require Psychotherapy. (CCR, title 9, § 1810.212, 1810.216, 1810.314(d)(e).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the MHP's written documentation standard guidelines. • Review the Written Weekly Schedule for: A. Required service components including requirements for community meetings and *Day Treatment Intensive* psychotherapy. B. Required and qualified staff. C. Documentation of the specific times, location, and assigned staff. • Community meetings must occur at least once a day and have the following staffing: ○ For Day Treatment Intensive: Staff whose scope of practice includes psychotherapy. ○ For Day Rehabilitation: Staff who is a physician, licensed/waivered/registered psychologist, clinical social

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
				worker, marriage and family therapist, or professional clinical counselor, registered nurse, psychiatric technician, licensed vocational nurse, or mental health rehabilitation specialist. • The MHP must retain the authority to set additional higher or more specific standards than those set forth in the MHP Contract, provided the MHP's standards are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary Day Treatment Intensive and Day Rehabilitation. • Psychotherapy does not include physiological interventions, including medication intervention. • Day Rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.
B.	1) There is documentation of the total number of minutes/hours the beneficiary actually attended the program each day. 2) If the beneficiary is absent, documentation that includes: A. The total time (number of hours and minutes) the beneficiary actually attended the program. B. Verification the beneficiary attended for at least least 50 percent of the hours of the program operation; **AND**, C. A separate entry in the medical record documenting the reason for the absence. (CCR, title 9, § 1840.112(b)(6).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review progress notes for: A. Documentation of attendance in the total number of minutes/hours. B. *Day Treatment Intensive* and *Day Rehabilitation* services were provided as claimed. C. If the beneficiary is unavoidably absent and does not attend the scheduled hours of operation, there is a separate entry

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
				in the medical record documenting the reason and the total minutes/hours of actual attendance. • Per the MHP Contract, in cases where absences are frequent, it is the responsibility of the Contractor to ensure that the provider re-evaluates the beneficiary's need for the *Day Rehabilitation* or *Day Treatment Intensive* program and takes appropriate action.
C.	When claiming for the continuous hours of operation for Day Treatment Intensive and Day Rehabilitation, the program provides: 1. For Half Day: Face-to-face services a minimum of three hours each program day. 2. For Full Day: Face-to-face services for more than 4 hours per day. CCR, title 9, § 1810.318			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review Written Weekly Schedule and other documentation to ensure this requirement is met. • Breaks between activities, as well as lunch and dinner breaks, do not count toward the total continuous hours of operation for purposes of determining minimum hours of service.
D.	The program includes the following staffing: 1. Day Treatment Intensive programs include Psychotherapy provided by a licensed, waivered, or registered staff practicing with their scope of practice. 2. Day Treatment Intensive and Day Rehabilitation programs have at least one			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	person present and available to the group in the therapeutic milieu. CCR, title 9, § 1810.314(d)(e)			**GUIDANCE:** • Review Written Weekly Schedule progress notes, and other documentation to determine if the required and qualified staff are available for all scheduled hours of operation.
E.	Documentation requirements for Day Treatment Intensive include: 1. Daily Progress Notes on activities attended. 2. Weekly Clinical Summary. Documentation requirements for Day Rehabilitation include: 1. Weekly Progress Notes.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review for: A. Required documentation timeliness/frequency for *Day Treatment Intensive and Day Rehabilitation.* B. Required and qualified staff documenting and providing the service. C. Required standards for all entries in the medical record. • The *Day Treatment Intensive* weekly clinical summary must be reviewed and signed by a physician, a licensed/ waivered/registered psychologist, clinical social worker, marriage and family therapist, or professional clinical counselor; or a registered nurse who is either staff to the *Day Treatment Intensive* program or the person directing the service.
	1) Documentation requirements for both Day Treatment Intensive and Day Rehabilitation include: 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. A. This contact is face-to face or by an alternative method such as email, telephone, etc. B. This contact focuses on the role of the support person in supporting the beneficiary's community reintegration.			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	C. This contact occurs outside the hours of operation and outside the therapeutic program. CCR, title 9, § 1810.112(b)(6)			
	2) All entries in the beneficiary's medical record include: A. The date(s) of service; B. The signature of the person providing the service (or electronic equivalent); C. The person's type of professional degree, licensure or job title; D. The date of signature; E. The date the documentation was entered in the beneficiary record; and F. The total number of minutes/hours the beneficiary actually attended the program.			
F.	There is a Written Program Description for Day Treatment Intensive and Day Rehabilitation that: 1) Describes the specific activities of each service and reflects each of the required components described in the MHP Contract.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review the Written Program Description and Written Weekly Schedule to determine if: A. There are specific activities described for each service component.
	2) Includes a Mental Health Crisis Protocol.			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	3) Includes a Written Weekly Schedule that: a) Identifies when and where services are provided and by whom; and b) Describes the qualifications and scope of services of program staff. CCR, title 9, § 1810.212, 1810.213.			B. All required service components are reflected in the Written Program Description, as well as indicated on the Written Weekly Schedule. C. Required and qualified staff are available for all scheduled hours of operation. • Often the Mental Health Crisis Protocol is contained in the Written Program Description • The Weekly Schedule may be a standard consistent schedule; however, if the schedule changes from week to week, all weekly schedules for the review period must be made available. • If the MHP uses *Day Treatment Intensive* and/or *Day Rehabilitation* staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), there must be documentation of the scope of responsibilities for these staff and the specific times in which *Day Treatment Intensive* or *Day Rehabilitation* activities are being performed exclusive of other activities.

SECTION J CHART REVIEW — SD/MC HOSPITAL SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
I.	***Medical Necessity***			
A.	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)(R) CCR, title 9, § 1820.205(a)(1)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Refer to CCR, title 9, chapter 11, section 1820.205 medical necessity criteria for reimbursement of Psychiatric Inpatient Hospital Services.
B.	The beneficiary meets criteria in both B(1-2) below: 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. (CCR, title 9, § 1820.205(a)(2)(A); C.F.R. SECTION 456.160)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review medical record documentation. • The documentation must indicate why the "further psychiatric evaluation" can only be conducted in an inpatient psychiatric unit.

CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
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: a) Has symptoms or behaviors due to a mental disorder or emotional disturbance that (one of the following): A. Represents a current danger to self or others, or significant property destruction. B. Prevents the beneficiary from providing for, or utilizing food, clothing or shelter. C. Presents a severe risk to the beneficiary's physical health. D. Represents a recent, significant deterioration in ability to function. (CCR, title 9, § 1820.205(a)(2)(B)(1-2); 42 C.F.R. § 456.170-171)			• The documentation must indicate why the "medication treatment" can only be conducted in an inpatient psychiatric unit.
b) Requires admission for one of the following: A. Further psychiatric evaluation. B. Medication treatment. C. Other treatment which could reasonably be provided only if the beneficiary were hospitalized. (CCR, title 9, § 1820.205(a)(2)(B)(1-2); 42 C.F.R. § 456.170-171)			

SECTION J CHART REVIEW — SD/MC HOSPITAL SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
II.	***Continued Stay Services***			
A.	The beneficiary's continued stay services in a psychiatric inpatient hospital meet one of the following reimbursement criteria: 1) Continued presence of indications which meet the medical necessity criteria for psychiatric inpatient hospital services. (CCR, title 9, § 1820.205(b)(1).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review medical record documentation.
	2) Serious adverse reaction to medication, procedures, or therapies requiring continued hospitalization. (CCR, title 9, § 1820.205(b)(2).)			
	3) Presence of new indications which meet medical necessity criteria for psychiatric inpatient hospital services. (CCR, title 9, § 1820.205(b)(3).)			
	4) Need for continued medical evaluation or treatment that could only have been provided if the beneficiary remained in a psychiatric inpatient hospital. (CCR, title 9, § 1820.205(b)(4).)			

SECTION J CHART REVIEW — SD/MC HOSPITAL SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
III.	***Administrative Day Services***			
A.	If payment has been authorized for administrative day services, the following requirements are met: 1) During the hospital stay, the beneficiary previously met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services. (CCR, title 9, § 1820.230(L)(5)(A).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review medical record documentation. • Requests for MHP payment authorization for administrative day services shall be approved by the hospital's Utilization Review Committee when both of the conditions are met: • The MHP or its designee can waive the requirement 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. • Examples of status include but are not limited to: o No beds available, o Patient not accepted; o Patient accepted and on waiting list; o Patient accepted and is # "x" on the waiting list. o Patient accepted and will transfer on "date" o Patient rejected. • Faxing a package or leaving a message is not considered a status.
	2) There is no appropriate, non-acute treatment facility within a reasonable geographic area. (CCR, title 9, § 1820.230(L)(5(B).)			
4c.	3) The hospital documents contacts with a minimum of five (5) appropriate, non-acute treatment facilities per week subject to the following requirement: 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: a) The status of the placement option. b) Date of the contact. c) Signature of the person making the contact. (CCR, title 9, § 1820.230(L)(5)(B).)			

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
IV.	***Information Requirements***			
A.	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; 42 C.F.R. § 438.10(d)(2), (4)-(5).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • If beneficiary is LEP, review to determine whether interpretive services were offered. • Review medical record documentation. • Review inpatient Implementation Plan (IP). • Review evidence that, when applicable, service-related personal correspondence is in the beneficiary's preferred language. • As needed, review evidence that beneficiaries are provided information in an alternate format.
B.	When applicable, there is documentation in the beneficiary's medical record that services were provided, or offered, in the beneficiary's preferred language. (CCR, title 9, § 1810.410)			
C.	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. (42 C.F.R. § 438.10(d)(6).)			
D.	1) A beneficiary has the right to receive information in accordance with the language and format requirements in 42 C.F.R. § 438.10(d). (42 C.F.R. §438.100(b)(2)(i).)			
	2) 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			

SECTION J CHART REVIEW — SD/MC HOSPITAL SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
	ability to understand. (42 C.F.R. §438.100(b)(2)(iii).)			
E.	The MHP documents in the individual's medical record whether or not the beneficiary has executed an advance directive. (42 C.F.R. part 417(K)(iii).)			
V.	***Screening, Referral and Coordination Requirements***			
A.	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; 42 C.F.R. § 438.208(b)(2).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Use "Admission Summary Worksheet" and "Continued Stay Summary Worksheet." • Review medical record documentation. • Review MHP inpatient IP.
A.	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, title 9, § 1810.310(a)(2)(A).)			
VI.	***Scope of Practice Requirements***			
A.	Services are delivered by licensed staff within their scope(s) of practice.			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Provider license(s)

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
				☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review medical record documentation.
VII.	***Written Plan of Care Requirements***			
A.	The beneficiary has a written plan of care that includes the following elements: 1) Diagnoses, symptoms, complaints, and complications indicating the need for admission. (42 C.F.R. part 456.180(b)(1).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ Beneficiary medical records ☐ Provider license(s) ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review medical record documentation. • Look for physician's signature. • 42 C.F.R. § 456.180 Individual written plan of care. (a) 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. • CCR Title 9 § 1820.230. MHP Payment Authorization by a Utilization Review Committee. (a) MHP payment authorization for psychiatric inpatient hospital services provided by a SD/MC hospital, if not made by an MHP's Point of Authorization pursuant to Section 1820.220, shall be made by the hospital's
	2) A description of the functional level of the beneficiary. (42 C.F.R. part 456.180(b)(2).)			
	3) 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).)			
	4) Descriptions of the types of interventions/modalities, including a detailed description of the interventions to be provided (which are consistent with the qualifying diagnosis and includes the frequency and			

CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
duration for each intervention). (42 C.F.R. § 456.180(b)(4).)			Utilization Review Committee. (b) The hospital's Utilization Review Committee or its designee shall approve or deny the initial MHP payment authorization no later than the third working day from the day of admission. • Verify the physician did not establish a written plan of care prior to the authorization of services which must be done by the hospital Utilization Review Committee or its designee no later than the third working day from the day of admission. • Parents, family members, and other advocates can be included in this process as selected by the adult client. • Look for client's signature or statement describing client participation. • If beneficiary refused or was unavailable to sign, look for a documented explanation of the refusal or unavailability.
5) Any orders for: a) Medications. b) Treatments. c) Restorative and rehabilitative services. d) Activities. e) Therapies. f) Social services. g) Diet. h) Special procedures recommended for the health and safety of the beneficiary. (42 C.F.R. § 456.180(b)(4).)			
6) Plans for continuing care, including review and modification to the plan of care. (42 C.F.R. § 456.180(b)(5).)			
7) Plans for discharge. (42 C.F.R. § 456.180(b)(6).)			
8) Documentation of the beneficiary's degree of participation in and agreement with the plan.			
9) Documentation of the physician's establishment of the plan. (42 C.F.R. § 456.180(c).)			

SECTION K Utilization Review -SD/MC Hospital SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
I. Utilization Review Plan				
A.	The SD/MC Hospital has a Utilization Review (UR) Plan that: a) Provides for a Utilization Review Committee (URC) to perform UR b) Describes the organization, composition, and functions of the committee. c) Specifies the frequency of the committee meetings. CCR, title 9, § 1820.230; C.F.R. 42 § 456(D)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ UR Plan ☐ URC Charter ☐ URC Minutes ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review IP, MHP UR Plan, and Utilization Review Committee (URC) minutes. • Identify URC members. • Look at licenses of members. • Are URC meetings held at the frequency specified? • What issues/trends are identified by the URC? • Has the MHP/Hospital resolved issues raised by URC?

SECTION K Utilization Review -SD/MC Hospital SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	The UR plan includes the: a) Identification of the recipient. b) The name of the recipient's physician. c) The date of admission. d) The beneficiary plan of care. e) Initial and subsequent continued stay review dates. f) Reasons and plan for continued stay (if the attending physician believes continued stay is necessary). g) Other supporting material that the committee believes appropriate to be included in the record. (42 C.F.R. part 456.211-213; 42 C.F.R. part 456.180; 42 C.F.R. parts 456.233 and 456.234)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ UR Plan ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review UR plan to determine if the required information is present. • Do the medical records include all of the required information?

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
C.	The UR plan includes the following review criteria for continued stay in the psychiatric hospital: a) Determination of need for continued stay. (42 C.F.R. part 456.231) b) Evaluation criteria for continued stay. (42 C.F.R. part 456.232) c) Initial continued stay review date. (42 C.F.R. part 456.233) d) Subsequent continued stay review dates.(42 C.F.R. part 456.234) e) Description of methods and criteria for continued stay review dates; length of stay modification. (42 C.F.R. part 456.235) f) Continued stay review process. (42 C.F.R. part 456.236) g) Notification of adverse decisions. (42 C.F.R. part 456.237)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ UR Plan ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Does the UR plan include all of the required review elements? • Is there evidence on the UR worksheets that shows the UR plan is followed in practice? • Is the documentation of the determination of need for continued stay required? • Is the evaluation for continued stay criteria documented? • Are the dates written? • Are the methods and criteria for documentation described? • Do the methods include a description of how the length of stay may be modified? • Is the continued stay review process documented? • Is the process for notification of adverse decision documented?

SECTION K Utilization Review -SD/MC Hospital SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
D.	The UR plan must describe: a) The types of records that are kept by the committee; and b) (b) The type and frequency of committee reports and arrangements for their distribution to appropriate individuals. (42 C.F.R. part 456.212)			
E.	The UR plan must provide that the identities of individual beneficiaries in all UR records and reports are kept confidential. (42 C.F.R. part 456.213)			
II. Medical Care Evaluations				

SECTION K Utilization Review -SD/MC Hospital SERVICES

	CRITERIA	FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
A	Regarding Medical Care Evaluations (MCEs) or equivalent studies, the UR plan contains the following: a) A description of the methods that the URC uses to select and conduct MCE or equivalent studies. (42 CFR §§ 456.241(a)(b) and 456.242(b)(1).) b) 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 CFR § 456.242(b)(2).) c) Documentation that the MCE or equivalent studies have been analyzed. (42 CFR §456.242(b)(3).) d) 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 CFR § 456.242(b)(4).)			**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ ☐ UR Plan ☐ MCEs or equivalent studies for each year ☐ Other evidence deemed appropriate by review team **GUIDANCE:** • Review UR Plan. • Identify description of methods used to select and conduct MCE or equivalent studies. • What does the MHP identify as the MCE equivalent? • Review current and past MCE or equivalent studies for two years and published results; URC minutes related to MCE study findings; analysis of MCE or equivalent studies; documentation of improved quality care; changes in use of facilities and services; documented actions taken to correct or investigate deficiencies or problems in the review process; and recommendations for hospital care procedures.

SECTION K Utilization Review -SD/MC Hospital SERVICES

CRITERIA		FINDING Y	FINDING N	INSTRUCTIONS TO REVIEWERS
B.	The contents of the MCE or equivalent studies meet federal requirements. (42 CFR § 456.243)			**GUIDANCE:** • Review current and past MCE or equivalent studies for two years.
C.	At least one MCE or equivalent study has been completed each calendar year. (42 CFR § 456.245)			
D.	An MCE or equivalent study is in progress at all times. (42 CFR § 456.245)			
E.	The SD/MC hospital has a beneficiary documentation and medical record system that meets the requirements of the contract between the MHP and the department and any applicable requirements of State, federal law and regulation. (MHP Contract)			