STATE DEPARTMENT OF HEALTH CARE SERVICES
PROGRAM OVERSIGHT AND COMPLIANCE

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

FISCAL YEAR (FY) 2014-2015

CONTENTS

Protocol Sections

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

In accordance with Welfare and Institutions Code (W&IC) section 5614 this serves to notify the County Mental Health Plan (MHP) pursuant to CCR, title 9, chapter 11, sections 1810.325, 1810.380(b), 1810.385, and W&IC section 14712(e), that whenever the Department determines that a MHP has failed to comply with part or any of the regulations:

1. The Department may terminate or cancel its contract agreement with an MHP by delivering written notice of termination to the MHP at least 180 calendar days prior to the proposed effective date of termination.

2. The Department may impose sanctions, including, but not limited to, fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to prompt and ensure contract and performance compliance. If fines are imposed by the Department, they may be withheld from the state matching funds provided to an MHP for Medi-Cal Specialty Mental Health Services.

3. The Department may impose one or more of the civil penalties upon an MHP which fails to comply with the provisions of Part 2.5, Division 5, and Articles 4 and 5, Chapter 8.8, Part 3, Division 9, W&IC, the provisions of this chapter, or the terms of the MHP's Contract with the Department.

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 shall 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 shall not be appealable to the Department. Except for terminations pursuant to section 1810.325(c), the Department shall 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 shall grant or deny the appeal in whole or in part within 30 calendar days after receipt of the appeal. The Department shall suspend any proposed action until the Department has acted on the MHP's appeal.

Following is the procedure for accessing Program Policy and Quality Assurance Branch, County Support Unit:

The staff of the Quality Assurance Section, County Support Unit act as contract liaisons and are available to assist MHP staff to address questions or concerns and to access resources. County Support staff are responsible for approving amendments to MHP implementation plans and providing MHPs assistance addressing issues identified through the DHCS Compliance and External Quality Review Organization reviews.

To obtain assistance, please contact your county liaison at CountySupport@dhcs.ca.gov .

ITEMS COVERED IN THE COUNTY MENTAL HEALTH PLAN ATTESTATION

Section A: Access	
1.	The MHP shall ensure that it makes a good faith effort to give affected beneficiaries written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Code of Federal Regulations (CFR), title 42, section 438.10(f)(5).
2.	The MHP shall have written policies regarding beneficiary rights. CFR, title 42, section 438.100(a),(b) and (d); DMH Letter No. 04-05.
3.	The MHP shall ensure that it complies with cultural competence and linguistic requirements including the development and implementation of a cultural competence plan. CCR, title 9, chapter 11, section 1810.410. DMH Information Notice 10-02, Enclosure, Criterion 7, Section III, C, Page 22, Criterion 7, Section IV, A, Page 22, Criterion 5, Section IV, A, Pages 18 & 19, and DMH Information Notice No. 10-17, Enclosure, Criterion 7, Section III, C, Page 17, Criterion 7, Section IV, A, Page 18, and Criterion 5, Section II, Page 14. Title VI, Civil Rights Act of 1964 (U.S. Code 42, section 2000d; CFR, title 45, Part 80).
4.	The MHP must maintain written policies and procedures that meet the requirements for advance directives. CFR, title 42, sections 422.128, 438.6(i)(2), 438.6(i)(l)(3) and (4), and 489.100.
5.	The MHP must maintain written policies and procedures to ensure beneficiaries are not discriminated against based on whether or not the beneficiary has executed an advance directive. CFR, title 42, sections 438.6(i)(1),(2),(3); 422.128(b)(1)(ii)(F) and 417.436 (d)(iv).
6.	The MHP must maintain written policies and procedures that provides for the education of staff concerning its policies and procedures on advance directives. CFR, title 42, sections 438.6(i); 422.128(b)(1)(ii)(H) and 417.436(d)(1)(vi).
7.	The MHP shall have in place, and follow written policies and procedures and have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. CFR, title 42, section 438.210.
8.	The MHP shall provide out-of-plan services to beneficiaries placed out of county. CCR, title 9, chapter 11, sections 1830.220 and 1810.365, Welfare and Institutions Code (W&IC), sections 14716 and 14717 and DMH Information Notice No. 97-06, D, 4.

ITEMS COVERED IN THE COUNTY MENTAL HEALTH PLAN ATTESTATION - continued

9.	The MHP shall ensure its compliance with requirements regarding authorization, documentation, provision and reimbursement of services when a child is in a foster care, KinGAP or Aid Adoptive Parents (AAP) aid code and residing outside his or her county of origin. The MHP shall ensure that it complies with the timelines when processing or submitting authorization requests for children in a foster care, AAP, or KinGAP aid code living outside his or her county of origin. CCR, title 9, chapter 11, section 1830.220 (b)(3) and (b)(4)(A); W&IC sections, 11376, 16125, 14716; 14717 and 14718; DMH Information Notice No. 09-06, DMH Information Notice No. 97-06 and DMH Information Notice No. 08-24.
10.	The MHP shall ensure access for foster care children outside his/her county of adjudication and ensure that it complies with the use of standardized contract, authorization procedure, documentation standards and forms issued by DMH, unless exempted by DHCS. CCR, title 9, chapter 11, sections 1810.220.5, 1830.220 (b)(3), and b(4)(A), DMH Information Notices No. 09-06, Page 2, No. 08-24 and No. 97-06, D, 4, W&IC sections 14716, 14717, 11376, 14684, and 16125.
11.	The MHP shall ensure that its grievance, appeal and expedited appeal processes contain the requirements, in CCR, title 9, chapter 11**,** and CFR, title 42 regulations. CFR, title 42, sections 438.402 and 438.406: CCR, title 9, chapter 11, sections 1850.205, 1850.206, 1850.207, and 1850.208.
12.	The MHP shall ensure that staff making decisions on grievance, appeal, and expedited appeals have the appropriate clinical expertise to treat the beneficiary's condition. CFR, title 42, section 438.406(a)(3)(ii), and CCR, title 9, chapter 11, section 1850.205(c)(9).
13.	The MHP shall ensure that when it denies a request for expedited appeal resolution, it will 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 and provide written notice within two calendar days of the date of the denial. The written notice of the denial of the request for an expedited appeal is not a Notice of Action as defined in Cal. Code Regulations., title 9, chapter 11, section 1810.230.5. CFR, title 42, section 438.408(d)(2)(ii), and CCR, title 9, chapter 11, section 1850.208(f)(2).
14.	The MHP shall ensure that it posts notices explaining grievance, appeal, and expedited appeal process procedures in locations at all MHP provider sites sufficient to ensure that the information is readily available to both beneficiaries and provider staff. CCR, title 9, chapter 11, section 1850.205(c)(1)(B).

ITEMS COVERED IN THE COUNTY MENTAL HEALTH PLAN ATTESTATION – continued

15.	The MHP shall ensure that forms that may be used to file grievances, appeals and expedited appeals, and self-addressed envelopes are available for beneficiaries to pick up at all MHP provider sites without having to make a verbal or written request to anyone. CCR, title 9, chapter 11, section 1850.205(c)(1)(C).
16.	The MHP shall ensure that individuals making decisions on grievances and appeals were not involved in any previous level of review or decision-making. CFR, title 42, section 438.406(a)(3)(i).
17.	The MHP shall ensure that grievances are resolved within established timeframes and that any required notice of an extension is given. CFR, title 42, section 438.408(a),(b)(1) and CCR, title 9, chapter 11**,** section 1850.206(b)
18.	The MHP shall ensure that appeals are resolved within established timeframes and that any required notice of an extension is given. CFR, title 42, section 438.408(a),(b)(2) and CCR, title 9, chapter 11, section 1850.207(c).
19.	The MHP shall ensure that expedited appeals are resolved within established timeframes and that any required notice of an extension is given. CFR, title 42, section 438.408(a),(b)(3) and CCR, title 9, chapter 11, section 1850.208.
20.	The MHP shall 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).
21.	The MHP shall 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 W&IC, section 5614 (b)(4).
22.	The MHP shall ensure that adult and children performance outcome system data is reported. W&IC, section 5610; County Performance Contract.

ITEMS COVERED IN THE COUNTY MENTAL HEALTH PLAN ATTESTATION – continued

Section G: Provider Relations	
23.	The MHP shall have written policies and procedures for selection, retention, credentialing and re-credentialing of providers; the provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. CFR, title 42, section 438.214(a)-(e).
24.	The MHP shall ensure that it oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor and before any delegation evaluates the prospective subcontractor's ability to perform the activities to be delegated. CFR, title 42, section 438.230(a).
25.	The MHP shall ensure that it provides the information specified at CFR, title 42, section 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract. CFR, title 42, section 438.414.

SECTION A **ACCESS**

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
1a.	Does the Mental Health Plan (MHP) provide beneficiaries with a booklet upon request and when first receiving a Specialty Mental Health Service (SMHS)?			**NOTE:** How does the MHP ensure that this requirement is met? • Review evidence that a booklet and a provider list are issued upon first receiving a SMHS and upon request.
1b.	Does the Mental Health Plan (MHP) provide beneficiaries with a current provider list upon request and when first receiving a Specialty Mental Health Service (SMHS)?			
• *CFR, title 42, section 438.10* • *CCR, title 9, chapter 11, section 1810.360(d)* • *CMS/DHCS section 1915(b) Waiver*		**OUT OF COMPLIANCE:** • No evidence that the MHP is providing a booklet and a provider list to beneficiaries upon first receiving a Specialty Mental Health Service. • Evidence reviewed indicates the MHP does not provide a booklet and a provider list upon request.		
2a.	Regarding the provider list, does the provider list contain: 1. Names of Providers?			**NOTE:** When reviewing larger counties, a regionalized provider list is ok. The provider list can include organizational, group, and individual providers. • At a minimum, the services are to be categorized by psychiatric inpatient hospital, targeted case management, and/or all other SMHS.
	2. Locations?			
	3. Telephone numbers?			
	4. The non-English languages spoken by the current contracted providers?			
	5. Does the list show providers by category?			

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
2b.	• Does the provider list include alternatives and options for cultural services?			**NOTE:** Refer to MHP's Cultural Competence Plan Requirements (CCPR) for the definition of ethnic, racial, culture-specific specialties. • Documented evidence that the county/contractor 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 providers. • Look for ethnic, cultural specific providers. The county may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the county i.e. older adults, veterans, and Lesbian, Gay, Bisexual and Transgender (LGBT).
	• Does the provider list contain alternatives and options for linguistic services?			
2c.	Does the provider list identify a means to inform beneficiaries of providers that are not accepting new beneficiaries?			
• *CFR, title 42, section 438.10(f)(6)(i)and 438.206(a)* • *CCR, title 9, chapter 11, section 1810.410* • *DMH Information Notice No. 10-02, Enclosure, Page 24 and DMH Information Notice No. 10-17, Enclosure, Page 18* • *CMS/DHCS, section 1915(b) Waiver* • *MHP Contract Exhibit A, Attachment I*		**OUT OF COMPLIANCE:** • The provider list does not contain the names, locations, telephone numbers of and non-English languages spoken by contracted providers. • The provider list does not contain cultural/linguistic alternatives and options. • The provider list does not contain minimum required categories. • No means to identify providers who are not accepting new beneficiaries		

SECTION A **ACCESS**

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS / COMMENTS
3.	Is there evidence that the MHP is making efforts to include culture-specific providers and services in the range of programs offered?			**NOTE:** Does the MHP have evidence of mechanisms in place to track progress for the inclusion of culture-specific providers and services in the range of programs offered? • The MHP may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the county.
• *CFR, title 42, section 438.206(c)(2)* • *CCR, title 9, chapter 11, sections 1810.110(a) and 1810.410* • *CCR, tile 9, section 3320(a)(2)* • *DMH Information Notice No. 10-02, Enclosure, Page 24 and DMH Information Notice No. 10-17, Enclosure, Page 20* • *CMS/DHCS section 1915(b) Waiver* • *MHP Contract, Exhibit A, Attachment I*				**OUT OF COMPLIANCE:** • No evidence the MHP is making efforts to include culture-specific providers and services.
4a.	Is the beneficiary booklet available in English and in the MHPs identified threshold language(s)?			**NOTE:** Check on MHP's threshold language(s) per the DHCS MHSD Information Notice No. 13-09, dated 4/30/2013. • Check availability of culturally and linguistically appropriate written information in threshold languages in the beneficiary booklet.
4b.	Is the provider list available in English and in the MHPs identified threshold language(s)?			
• *CFR, title 42, section 438.10(c)(2),(3)* • *CCR, title 9, chapter 11, section 1810.410(c)(3)* • *DMH Information Notice No. 10-17, Enclosure, Page 18, DMH Information Notice No. 10-02, Enclosure, Page 23 and DHCS MHSD Information Notice No. 13-09, dated 4/30/2013*				**OUT OF COMPLIANCE:** • Beneficiary booklet and the provider list are not available in English and, when applicable, in the threshold language(s).

SECTION A **ACCESS**

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
Documentation: List documents reviewed that demonstrate compliance and provides specific explanation of reason(s) for in compliance or out of compliance.				
5a.	Does the MHP make written materials in English and the threshold language(s) available to beneficiaries in alternative formats?			**NOTE:** Written materials apply to informing materials (e.g. beneficiary booklet and additional written materials used by the MHP) such as general program literature. • Review evidence of the alternative formats available. • Are the alternative formats available in the threshold language(s), i.e. large print, audio versions or braille? • How does the MHP ensure this requirement is met?
5b.	Do these written materials take into consideration persons with limited vision?			
5c.	Do these written materials take into consideration persons with limited reading proficiency?			
• *CFR, title 42, section 438.10(d)(i),(ii)* • *CCR, title 9, chapter 11, sections 1810.110(a) and 1810.410(e)(4)*		**OUT OF COMPLIANCE:** • Informing materials and additional written materials in English and the threshold language(s) are not made available in alternative formats.		
6a.	Does the MHP inform beneficiaries that the information is available in alternative formats?			**NOTE:** How does the MHP inform beneficiaries that information is available in alternative formats, as well as, how to access those formats?
6b.	Does the MHP inform beneficiaries how to access alternative formats?			
• *CFR, title 42, section 438.10(d)(2)* • *MHP Contract, Exhibit A, Attachment I*		**OUT OF COMPLIANCE:** • There is no evidence the MHP is informing beneficiaries that information is available in alternative formats and how to access those formats.		

SECTION A **ACCESS**

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
7. 7a.	Regarding the under-served target populations: Is there evidence of community information and education plans that enable the MHP's beneficiaries' access to SMHS?			**NOTE:** "Under-served target populations" refers to beneficiaries with specific cultural and linguistic needs identified in the MHP's CCPR. Under-served communities are those groups who have low levels of access and/or use of mental health services, and who face pervasive institutional and socioeconomic barriers to obtaining health and mental health care. • Ask the MHP how the under-served target populations are identified in the CCPR. • Review evidence of community information and education plans utilized by the MHP (e.g. number of community presentations or forums and locations used to disseminate information about specialty mental health services, etc.)? • Is the MHP in compliance with its CCPR?
7b.	Is there evidence of outreach for informing under-served target populations of the availability of cultural/linguistic services and programs?			**NOTE:** Ask the MHP to describe its outreach efforts to inform all Medi-Cal beneficiaries of available services under the consolidation of specialty mental health services. • Review evidence of MHP's outreach efforts (e.g., calendar of events, sign-in sheets, tracking logs, etc.).
• *CCR, title 9, chapter 11, sections 1810.310(2)(A),(B) and 1810.410* • *CCR, tile 9, section 3320(a)(2)* • *DMH Information Notice No. 10-02, Enclosure, Page 25, and DMH Information Notice No. 10-17, Enclosure, Page 21* • *MHP Contract, Exhibit A, Attachment I* • *CMS/DHCS, section 1915(b) waiver*				**OUT OF COMPLIANCE:** • Not following Cultural Competence Plan Requirements (NFCCPR). • No evidence of community information and education plans. • No evidence of outreach to under-served target populations identified in the MHP's CCPR.

SECTION A **ACCESS**

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
8. 8a.	Regarding mental health services available to the persons who are homeless and hard-to-reach individuals: Is there evidence of assertive outreach to persons who are homeless with mental disabilities?			• Review evidence of assertive outreach to persons who are homeless (e.g., calendar of events, sign-in sheets, tracking logs, etc.).
8b.	Is there evidence of assertive outreach to hard-to-reach individuals with mental disabilities?			**NOTE:** Assertive outreach should make mental health services available to homeless and hard-to-reach individuals with mental disabilities. • Review evidence of assertive outreach to the hard-to-reach individuals (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.
• *W&IC, section 5600.2(d)*		**OUT OF COMPLIANCE:** • No evidence of any assertive outreach efforts to persons who are homeless and hard-to-reach individuals.		

SECTION A **ACCESS**

	CRITERIA	IN COMPLIANCE Y	IN COMPLIANCE N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
9. 9a.	Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: 1. Does the MHP provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county?			**NOTE:** DHCS review team members will test the 24/7 toll-free telephone number in both English and other language(s).
	2. Does the toll-free telephone number provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met?			
	3. Does the toll-free telephone number provide information to beneficiaries about services needed to treat a beneficiary's urgent condition?			
	4. Does the toll-free telephone number provide information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes?			
	• *CCR, title 9, chapter 11, sections 1810.405(c)(d) and 1810.253* • *CMS/DHCS, section 1915(b) waiver*			

SECTION A ACCESS

CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS

Access 9a **Regarding the 24/7 toll-free telephone number:**		**Compliant?** Yes	No
1	Does the MHP provide a 24/7 toll-free number, with language capability?		
2	Does the toll-free number provide information about how to access SMHS including assessing medical necessity?		
3	Does the toll-free number provide information to treat an urgent condition?		
4	Does the toll-free number provide information on beneficiary problem resolution and state fair hearings?		

Test Calls	Date of Test Call	*Language	**Category	***Method	Comments	Yes	No
					= =		
					= = =		
				%			
				%			

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS / COMMENTS
9b.	1. Does the MHP provide a statewide (24/7) toll-free telephone number that provides adequate TTY/TDD or Telecommunications Relay Services?			**NOTE:** TTY (Teletype writer)/TDD (Telecommunication Device for the Deaf is an electronic device for text communication via a telephone line, used when one or more of the parties have hearing or speech difficulties. A Telecommunications Relay Service, is an operator service that allows people who are Deaf, Hard–of–Hearing, Speech–Disabled, or Deaf and Blind to place calls to standard telephone users via a keyboard or assistive device. Originally, relay services were designed to be connected through a TTY/TDD or other assistive telephone device. • If TTY/TDD or Telecommunications Relay Services is utilized, how are beneficiaries informed of the toll-free telephone number? • Ask the MHP to provide evidence of TTY/TDD or Telecommunications Relay Services provided, including how the MHP ensures linguistic capabilities in all languages. • Review practices that the MHP has in place for meeting clients' language needs.
	• *CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1)* • *CFR, title 42, section 438.406 (a)(1)* • *DMH Information Notice No. 10-02, Enclosure, Page 21, and DMH Information Notice No. 10-17, Enclosure, Page 16* • *MHP Contract, Exhibit A, Attachment I*			**OUT OF COMPLIANCE:** • MHP does not meet 24/7 toll-free requirements as evidenced by the results of DHCS test calls. • Lack of linguistic capacity, including TTY/TDD or Telecommunications Relay Services, in all languages spoken by beneficiaries of the county as evidenced by the results of DHCS test calls

SECTION A **ACCESS**

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS / COMMENTS
10.	Regarding the MHP maintaining a written log of initial requests that meets Title 9 requirements:			DHCS staff have conducted test calls for initial requests for SMHS to verify that all initial requests for SMHS are logged. **NOTE:** The MHP shall maintain a written log of the following: Name of the beneficiary Date of the request for SMHS Initial disposition of the request • Initial request for SMHS made by a beneficiary must be recorded in a written log. These requests may be made by phone, in person, or in writing. • Request the MHP to describe the logging system. • MHP may maintain the log electronically. • Review the written logs for the dates of the DHCS test calls.
10a.	Does the written log contain the name of the beneficiary?			
10b.	Does the written log contain the date of the request?			
10c.	Does the written log contain the initial disposition of the request?			
•	*CCR, title 9, chapter 11, section 1810.405(f)*			**OUT OF COMPLIANCE:** • Written log of initial requests does not meet Title 9 requirements. • The MHP is not recording required information. • The DHCS review team's test calls of initial requests are not logged.

SECTION A **ACCESS**

CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS

Access 10a,b,c **Regarding the Written Log of Initial Requests:**					**Compliant?**	
Did the Test Call Log contain: *If yes, put a √ in the column*	**Name**	**Date**	**Disposition**	**Comments**	**Yes**	**No**
			%			
			%			

SECTION A **ACCESS**

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
11. 11a.	Review evidence that Limited English Proficient (LEP) individuals are informed of the following in a language they understand: LEP individuals have a right to free language assistance services.			**NOTE:** CCR, title 9, chapter 11, section 1810.410, requires that there be policies and procedures to assist beneficiaries who need oral interpreter services in languages other than threshold languages to access the SMHS or related services available through "Key points of contact." Interpreter services mean oral and sign language. • Review the MHP's P&Ps. • Is the MHP following its CCPR? • CFR, title 42, section 438.10 (c)(4) and (5) requires MHPs to make oral interpretation services available and make these services available free of charge to each potential beneficiary and beneficiary. This applies to all non-English languages, not just those that the State identifies as prevalent. • Ask the MHP how these services are made available.
11b.	LEP individuals are informed how to access free language assistance services.			• Review evidence that beneficiaries are informed in writing in English and other languages of their rights to language assistance services, including posting of this right.

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
11c.	Is there documented evidence to show that the MHP offered interpreter services?			**NOTE:** Review evidence in medical records, or elsewhere, of offers of interpreter services, availability of such services, and/or how beneficiaries are linked to appropriate services. • Review MHP policies and procedures to assist beneficiaries who need oral interpreter services in languages other than threshold languages to access the SMHS or related services available through the "Key points of contact". • Interpreter services mean oral and sign language. • "Primary language" means that language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary. • MHP to provide medical records in which interpreter services were provided. • Review findings from chart reviewers regarding interpreter services.
• *CFR, title 42, section 438.10 (c)(4) , 438.6(f)(1), 438.100(d), CFR, title 28, Part 35, 35.160(b)(1), CFR, title 28, Part 36, 36.303(c)* • *CCR, title 9, chapter 11, section 1810.410(a)-(e)* • *DMH Information Notice No. 10-02, Enclosure, Page 22, and DMH Information Notice No. 10-17, Enclosure, Page 17* • *title VI, Civil Rights Act of 1964 (U.S. Code 42, section 2000d; CFR, title 45, Part 80)* • *MHP Contract, Exhibit A, Attachment I* • *CMS/DHCS, section 1915(b) waiver*				**OUT OF COMPLIANCE:** • No evidence that LEP individuals are informed of the right to free language assistance services. • No evidence that LEP individuals are informed how to access free language assistance services. • No documentation that the MHP offered interpreter services to assist beneficiaries who need interpreter services.

SECTION A **ACCESS**

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
Documentation: List documents reviewed that demonstrate compliance and provides specific explanation of reason(s) for in compliance or out of compliance.				
12.	Whenever feasible and at the request of the beneficiary, does the MHP provide an opportunity to change persons providing the SMHS, including the right to use culture-specific providers?			**NOTE:** • Ask the MHP to describe the processes for changing the persons who will provide the services. • Ask the MHP for the policy that describes the process. • Ask the MHP how these requests are tracked. • Review the requests/outcomes. Ask the MHP to show you examples of such a request being made, including initial request and the documented outcome.

• *CCR, title 9, chapter 11, sections 1810.310(4)(A) and 1830.225(a),(b)* • *CCR, title 9, section 3320(a)(2)* • *CFR, title 42, section 438.6(m)* • *DMH Information Notice No. 10-02, Enclosure, Page 24 and DMH Information Notice No. 10-17, Enclosure, Page 20* • *MHP Contract, Exhibit E*	**OUT OF COMPLIANCE:** • No evidence that the MHP provides an opportunity to change persons providing SMHS, including the right to use culture-specific providers.

SECTION A **ACCESS**

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS / COMMENTS
13. 13a.	Has the MHP developed a process to provide culturally competent services as evidenced by: 1. Is there a plan for cultural competency training for the administrative and management staff of the MHP?			**NOTE:** CCR, title 9, chapter 11, section 1810.410 requires that the MHP develop a plan to provide cultural competency training for the administrative and management staff of the MHP, the persons providing SMHS employed by or contracting with the MHP, to provide interpreter or other support services to beneficiaries. • Ask the MHP to describe the plan for cultural competency training that was noted in the CCPR. Ask the MHP to provide information on the current status of the cultural competency plan including specific efforts they have implemented during this triennial review period.
	2. Is there a plan for cultural competency training for persons providing SMHS employed by or contracting with the MHP?			
	3. Is there a plan to provide interpreter or other support services to beneficiaries?			
13b.	Implementation of training programs to improve the cultural competence skills of staff and contract providers.			**NOTE:** Review evidence of cultural competency trainings that have been implemented during the triennial review period.
13c.	A process that ensures that interpreters are trained and monitored for language competence (e.g., formal testing).			• Ask MHP to describe the process for ensuring that interpreters are trained and monitored for language competence.

CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
• *CCR, title 9, chapter 11, section 1810.410 (a)-(e)* • *DMH Information Notice No. 10-02, Enclosure, Pages 16 & 22 and DMH Information Notice No. 10-17, Enclosure, Pages 13 & 17* • *MHP Contract, Exhibit A, Attachment I*			**OUT OF COMPLIANCE:** • No evidence that the MHP has developed a plan to provide cultural competency training for all MHP staff and contracted providers to provide interpreter or other support services to beneficiaries. • No evidence that the MHP has implemented training programs. • No evidence that the MHP has a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

Documentation: List documents reviewed that demonstrate compliance and provides specific explanation of reason(s) for in compliance or out of compliance.				
14.	When the MHP is involved in the placement, does the MHP provide the DHCS issued Medi-Cal Services for Children and Young Adults: Early & Periodic Screening, Diagnosis & 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?			**The following information applies to items 14a-c:** **NOTE:** Obtain DHCS issued brochure used to provide information regarding the availability of EPSDT and TBS information. • Review the MHP's written procedures that ensure that the information is being provided when required. • The brochure is located on the DHCS website: http://www.dhcs.ca.gov/services/MH/Pages/EPSDT.aspx
14a.	1. At the time of admission to a Skilled Nursing Facility (SNF) with a Specialized Treatment Program (STP) for the mentally disordered?			
	2. At the time of admission to a Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution for Mental Diseases (IMD)?			

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
14b.	At the time of placement in a Rate Classification Level (RCL) 13-14 foster care group home.			
14c.	At the time of placement in a RCL 12 foster care group home when the MHP is involved in the placement.			
• *CCR, title 9, chapter 11, section 1810.310 (a)(1)* • *DMH Letter No. 01-07, Enclosures* • *DMH Letter No. 04-04, Enclosures* • *DMH Letter No. 04-11* • *DMH Information Notice No. 08-38* • *MHP Contract, Exhibit A, Attachment I*	**OUT OF COMPLIANCE:** • The MHP is not providing the EPSDT/TBS informing brochure as required. • The MHP does not have procedures for providing information as required. • There is no evidence that the procedures are being followed.			

SECTION B AUTHORIZATION

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
RE: HOSPITAL SERVICES UTILIZING A POINT OF AUTHORIZATION				
1. 1a.	Regarding the Treatment Authorization Requests (TARs): Are the TARs being approved or denied by licensed mental health or waivered/registered professionals of the beneficiary's MHP in accordance with title 9 regulations?			**NOTE:** Fee for Service hospitals shall submit a TAR to the MHP Point of Authorization of the beneficiary. • Review random sample of DHCS selected TARs to determine if qualified mental health professionals are approving/denying TARs in accordance with title 9 regulations. • Obtain list of MHP licensed/waivered/registered staff who review TARs and match it with the signature on the TARs.
1b.	Are all adverse decisions regarding hospital requests for payment authorization that were based on criteria for medical necessity or emergency admission being reviewed and approved in accordance with title 9 regulations by: 1) a physician 2) at the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under the psychologist's scope of practice.			**NOTE:** Review random sample of DHCS selected TARs that were affected by adverse decisions. • Adverse decision is based on medical necessity criteria. • Check TARs for evidence or supporting documentation, of physician review or when applicable, of psychologist review. • Check if a NOA-C is issued to the beneficiary when adverse decisions are rendered.
1c.	Does the MHP approve or deny TARs within 14 calendar days of the receipt of the TAR and in accordance with title 9 regulations?			**NOTE:** CCR, title 9, chapter 11, section 1810.242 states: "Receipt" means the receipt of a Treatment Authorization Request or other document. The "date of receipt" means the date the document was received as indicated by a date stamp made by the receiver or the fax date recorded on the document. For documents submitted by mail, the postmark date shall be used as the date of receipt in the absence of a date/time stamp made by the receiver. • Review random sample of DHCS selected TARs.

SECTION B AUTHORIZATION

CRITERIA	IN COMPLIANCE Y N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
• *CCR, title 9, chapter 11, sections 1810.242, 1820.220(c),(d), 1820.220 (f), 1820.220 (h), and 1820.215.* • *CFR, title 42, section 438.210(d)*		**OUT OF COMPLIANCE:** • TARs not being approved or denied by qualified staff in accordance with title 9 regulations. • Physician or, when applicable, a psychologist is not reviewing adverse decisions. • No physician signature regarding adverse decisions on the TAR or no evidence or supporting documentation of physician review. • The MHP is not approving or denying TARs within 14 calendar days of the receipt of the TAR and in accordance with title 9 regulations. **NOTE**: CCR, title 9, chapter 11, section 1810.242 states: "Receipt" means the receipt of a Treatment Authorization Request or other document. The "date of receipt" means the date the document was received as indicated by a date stamp made by the receiver or the fax date recorded on the document. For documents submitted by mail, the postmark date shall be used as the date of receipt in the absence of a date/time stamp made by the receiver.

SECTION B AUTHORIZATION

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
Authorization 1a, b, c				
Regarding TARs:				
				Yes / No
A.	Are TARs approved or denied by licensed or waivered/registered MH professionals?			
	Total number of TARs reviewed			
	Number of TARs that met staffing requirements			
	*Number of TARs that did **not** meet staffing requirements*			
	*Percentage of TARs **not in** compliance with staffing requirements*	%		
B.	Denials based on medical necessity approved by physician or psychologist?			
	Total number of adverse decisions based on medical necessity			
	Number of TARs in compliance with staffing requirements			
	*Number of TARs **not in** compliance with staffing requirements*			
	*Percentage of TARs **not in** compliance with staffing requirements*	%		
C.	Were all TARs approved witin 14 calendar days of receipt?			
	Total number of TARs reviewed			
	Number of TARs in compliance with timeline requirements			
	*Number of TARs **not in** compliance with timeline requirements*			
	Number of TARs unable to determine timeline compliance			
	*Percentage of TARs **not in** compliance*	%		

SECTION B AUTHORIZATION

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS / COMMENTS
RE: NON-HOSPITAL SPECIALTY MENTAL HEALTH SERVICES				
2.	The MHP may require that providers obtain MHP payment authorization of any or all SMHS as a condition of reimbursement. Are payment authorization requests being approved or denied by licensed mental health professionals or waivered/registered professionals of the beneficiary's MHP?			• Have the MHP describe the providers and non-hospital specialty mental health services subject to payment authorization. • Review payment authorization requests. • CFR, title 42, section 438.210(b)(3) : "Licensed psychiatric technicians and licensed vocational nurses may approve or deny such requests only when the provider indicates that the beneficiary to whom the specialty mental health services will be delivered has an urgent condition as defined in Section 1810.253."
• *CFR, title 42, section 438.210(b)(3)* • *CCR, title 9, chapter 11, sections 1830.215 (a-g) and 1810.253*				**OUT OF COMPLIANCE:** • MHP is not using appropriate staff to approve/deny authorizations. • MHP is using LPTs and LVNs when an urgent condition does not exist.

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
RE: UTILIZATION MANAGEMENT				

3.	Does the MHP have a payment authorization system in place that meets the requirements regarding Day Treatment Intensive and Day Rehabilitation in accordance with title 9 regulations?			**NOTE:** Review the procedure/system for informing providers and county staff of the need to request an MHP payment authorization. An MHP payment authorization refers to a written, electronic, or verbal authorization given by a MHP to a service provider.
				• Check that the procedure/system has assurances that payment is not being made without prior authorization.
				  • Review the Day Treatment requirements.
				  • An initial MHP payment authorization is required.
				  • An Advance Authorization if more than 5 days per week, or
				  • If continuation of Day Treatment Intensive at least every 3 months, or
				  • If continuation of Day Rehabilitation at least every 6 months.
				  • Review Day Treatment Intensive and Day Rehabilitation authorizations.
				  • DHCS chart reviewers to provide findings regarding Day Treatment Intensive and Day Rehabilitation compliance in regulatory and contractual requirements.

• *CCR, title 9, chapter 11, sections 1830.215 (e) and 1840.318.* • *DMH Information Notice 02-06, Enclosures, Pages 1-5* • *DMH Letter No. 03-03*				**OUT OF COMPLIANCE:** • Not following title 9 regulations. • No payment authorization system in place that meets requirements.

SECTION B AUTHORIZATION

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS

4.
 	
4a.
	Regarding authorization timeframes:
	
	For standard authorization decisions, does the MHP make an authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional days?
				• The MHP may require that providers obtain MHP payment authorization for any or all SMHS as a condition of reimbursement except for services provided to beneficiaries with emergency psychiatric conditions.
				
				• Review sample of MHP's authorization decisions.
				
				• Extension for an additional 14 calendar days is possible if:
				  • Beneficiary or provider requests an extension.
				  • MHP identifies need for additional information, documents the need and how the extension is in the beneficiary's best interest within its authorization records.
				  • If an extension is requested, review the process for notifying the beneficiary and a random sample of the written notifications.

Authorization 4a			
Standard authorization decisions			
			Y/N
Does MHP make an authorization decision and provide notice as expeditiously as health condition requires and within 14 calendar days of receipt of request for service?			
	Total number of authorization decisions reviewed		
	Number of authorization decisions in compliance with timeline requirement		
	Number of authorization decisions **not** in compliance with timeline requirement		
	Number of authorizations with extensions		
	Number of authorization decisions unable to determine timeline compliance		
	Percentage of authorizations **not in** compliance	%	

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
4b.	For expedited authorization decisions, does the MHP make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and within 3 working days following receipt of the request for service or, when applicable, within 14 calendar days of an extension?			**NOTE:** Expedited authorization decisions For cases in which a provider indicates, or the MHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service. • Review the MHP process for expedited authorization decisions. • Is the process in accordance with title 42 regulations? • If an extension is requested, review the process for notifying the beneficiary and a random sample of the written notifications.
•	*CFR, title 42, section 438.210(d)(1),(2)*			**OUT OF COMPLIANCE:** • The MHP is not making authorization decisions within the required timeframes. • The MHP is not providing notices within the required timeframes. • The MHP does not have a process for expedited authorization decisions.
5a.	Is there evidence that the MHP is reviewing Utilization Management (UM) activities annually, including monitoring activities to ensure that the MHP meets the established standards for authorization decision making.			• Review both hospital and non-hospital authorization processes and monitoring activities. • MHP to provide evidence of an annual review of the Utilization Management Program, e.g., this may be in the form of an annual report, may be documented in the QI minutes or the annual evaluation of the QI work plan.
5b.	Is there evidence that action is taken to improve performance if necessary?			
5c.	Is there evidence of a review of the consistency in the authorization process?			

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
•	*CCR, title 9, chapter 11, section 1810.440(b)(1),(2),(3)*			**OUT OF COMPLIANCE:** • No evidence that the MHP is reviewing Utilization Management activities annually.
6.	Regarding Notices of Action (NOAs):			**The following information applies to items 6a-e:**
6a.	NOA-A: Is the MHP providing a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible to any SMHS?			**NOTE:** Revised versions of NOAs are dated June 1, 2005. • Is the MHP issuing a NOA-A in accordance with the title 9 and title 42 requirements? • Review NOAs issued during the triennial review period. • The MHP shall retain copies of all Notices of Action issued to the beneficiaries in a centralized file accessible to the Department. • Review request-for-service logs for requests for services that did not receive an intake assessment appointment. • If utilizing a form different from the DHCS approved form, does it contain all the required elements?
6b.	NOA-B: Is the MHP providing a written NOA-B to the beneficiary when the MHP denies, modifies, or defers (beyond timeframes) a payment authorization request from a provider for SMHS?			**NOTE:** Is the MHP or its providers providing a NOA-B when payment authorization requests are denied, modified, or deferred beyond timeframes? • Review NOA-Bs issued during the triennial review period. • Review authorization requests.

SECTION B AUTHORIZATION

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
6c.	NOA-C: Is the MHP providing a written NOA-C to the beneficiary when the MHP denies payment authorization of a service that has already been delivered to the beneficiary as a result of a retrospective payment determination?			**NOTE:** Applies to both hospital and non-hospital service(s). • Review NOA-Cs issued during the triennial review period. • Does the MHP deny payment authorization of services that have already been delivered? • Review In-patient TARs for denied days and issuance of a NOA-C, when applicable.
6d.	NOA-D: Is the MHP providing a written NOA-D to the beneficiary when the MHP fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals?			**NOTE:** Review the grievances and appeals records to determine if the MHP has failed to act within the required timeframes. • Review NOA-Ds issued during the triennial review period. • Review the grievances/appeals log(s).
6e.	NOA-E: Is the MHP providing a written NOA-E to the beneficiary when the MHP fails to provide a service in a timely manner, as determined by the Contractor (MHP)?			**NOTE:** Review the MHP standards for the delivery of services in a timely manner. • Review NOA-Es issued during the triennial review period. • How does the MHP track such activity to determine if the services are delivered in a timely manner?
• *CFR, title 42, sections 438.10(c), 438.400(b) and 438.404(c)(2)* • *CCR, title 9, chapter 11, sections 1830.205(a),(b)(1),(2),(3), 1850.210 (a)-(j) and 1850.212* • *DMH Letter No. 05-03* • *MHP Contract, Exhibit A, Attachment I*				**OUT OF COMPLIANCE:** • There is evidence the MHP is not issuing NOAs per regulations. • The MHP is not using the revised versions of NOAs dated June 1, 2005.

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
7.	Does the MHP provide for a second opinion from a qualified health care professional within the MHP network, or arrange for the beneficiary to obtain a second opinion outside the MHP network, at no cost to the beneficiary?			**NOTE:** MHP network includes individual, group, and organizational providers. • CCR, title 9, chapter 11, section 1810.405(e) states: At the request of a beneficiary, the MHP of the beneficiary shall provide for a second opinion by a licensed mental health professional, other than a psychiatric technician or a licensed vocational nurse, employed by, contracting with or otherwise made available by the MHP when the MHP or its providers determine that the medical necessity criteria in CCR, title 9, chapter 11, sections 1830.205(b)(1), (b)(2) or(b)(3)(C) and section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The MHP shall determine whether the second opinion requires a face-to-face encounter with the beneficiary. • Review the MHP's second opinion process and procedures. • Ask how these requests are tracked.. • 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.
• *CFR, title 42, section 438.206(b)(3)* • *CCR, title 9, chapter 11, section 1810.405(e)*				**OUT OF COMPLIANCE:** • No evidence the MHP provides for a second opinion from a qualified health care professional within the MHP network. • No evidence that the MHP is arranging for a second opinion outside the MHP network, at no cost to the beneficiary. • The MHP does not provide for a second opinion process in accordance with title 9 and title 42 regulations.

SECTION C BENEFICIARY PROTECTION

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS / COMMENTS
1. 1a.	Regarding notice to the Quality Improvement Committee (QIC) and subsequent action: 1. Does the MHP have procedures by which issues identified as a result of the grievance process is transmitted to the MHP's QIC, the MHP's administration or another appropriate body within the MHP's organization?			**NOTE:** Review the procedures in place. • MHP to identify issues as a result of the grievance, appeal or expedited appeal.
	2. Does the MHP have procedures by which issues identified as a result of the appeal process is transmitted to the MHP's QIC, the MHP's administration or another appropriate body within the MHP's organization?			
	3. Does the MHP have procedures by which issues identified as a result of the expedited appeal process is transmitted to the MHP's QIC, the MHP's administration or another appropriate body within the MHP's organization?			
	4. Is there evidence that procedures for the grievance, appeal and expedited appeal processes has been followed?			
1b.	When applicable, has there been subsequent implementation of needed system changes?			• MHP to describe and give documented examples of implemented system changes.

SECTION C BENEFICIARY PROTECTION

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
• *CCR, title 9, chapter 11, sections 1850.205(c)(7), 1850.206, 1850.207 and 1850.208.*				**OUT OF COMPLIANCE:** • The MHP does not have procedures in place. • Evidence procedures not being followed. • Implementation of needed system changes not taking place.
2.	Has the MHP developed a beneficiary problem resolution process that meets title 9 and title 42 regulatory requirements for each of the following:			**NOTE:** CCR, title 9, chapter 11, section 1850.208 (a)(b) The expedited appeal process shall, 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.
2a.	A grievance process.			• MHP to resolve and notify within three (3) working days after receipt of expedited appeal.
2b.	An appeal process.			
2c.	An expedited appeal process.			

SECTION C BENEFICIARY PROTECTION

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS / COMMENTS
3.	The MHP is required to maintain a grievance, appeal, and expedited appeal log(s) that records the grievances, appeals, and expedited appeals within one working day of the date of receipt of the grievance, appeal, or expedited appeal. The log shall include:			**NOTE:** Verify information is present for each grievance, appeal and expedited appeal.
3a.	The name of the beneficiary.			
3b.	The date of receipt of the grievance, appeal, and expedited appeal.			
3c.	The nature of the problem.			
4a.	Does the MHP provide written acknowledgement of each grievance to the beneficiary in writing?			• Review examples of the MHPs written acknowledgement sent in response to the receipt of each grievance, appeal or expedited appeal.
4b.	Does the MHP provide written acknowledgement of each appeal to the beneficiary in writing?			
4c.	Does the MHP provide written acknowledgement of each expedited appeal to the beneficiary in writing?			

SECTION C BENEFICIARY PROTECTION

CRITERIA	IN COMPLIANCE Y N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
CFR, title 42, section 438.406(a)(2) *CCR, title 9, chapter 11, section 1850.205(d)(4)*		**OUT OF COMPLIANCE:** • MHP not acknowledging the receipt of each grievance/appeals/expedited appeal in writing.

Beneficiary Protection 4a,b,c				
				Y/N
4a.	Does the MHP provide written acknowledgment of each grievance to the beneficiary in writing?			
		Total number of grievances reviewed		
		Total number in compliance with requirement		
		Total number **not** in compliance with requirement		
		Percent out of compliance	%	
4b.	Does the MHP provide written acknowledgment of each appeal to the beneficiary in writing?			
		Total number of appeals reviewed		
		Total number in compliance with requirement		
		Total number **not** in compliance with requirement		
		Percent out of compliance	%	
4c.	Does the MHP provide written acknowledgment of each expedited appeal to the beneficiary in writing?			
		Total number of expedited appeals reviewed		
		Total number in compliance with requirement		
		Total number **not** in compliance with requirement		
		Percent out of compliance	%	

SECTION C BENEFICIARY PROTECTION

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
5a.	Is the MHP notifying beneficiaries, or their representatives, of the grievance disposition and is this being documented?			**NOTE:** Unless extension was requested, grievance or appeal disposition timeframes are no later than 60 calendar days for grievances; 45 calendar days for appeals, and 3 working days for expedited appeals. • How are the beneficiaries/representatives notified? • Review the grievance and appeal records regarding notification. • Review examples of the MHPs grievance and appeal decision letters.
5b.	Is the MHP notifying beneficiaries, or their representatives, of the appeal disposition and is this being documented?			
5c.	Is the MHP notifying beneficiaries, or their representatives, of the expedited appeal disposition and is this being documented?			
• *CFR, title 42, section 438.408(d)(1)(2)* • *CCR, title 9, chapter 11, sections 1850.206(b),(c), 1850.207(c),(h), and 1850.208(d),(e)*				**OUT OF COMPLIANCE:** • The MHP is not notifying the beneficiary or their representatives of the grievance or appeal disposition.

SECTION C BENEFICIARY PROTECTION

CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS

Beneficiary Protection 5a, b, c			**Y/N**
5a.	Is the MHP notifying beneficiaries of the grievance disposition and is this being documented?		
	Total number of grievances reviewed		
	Total number in compliance with requirement		
	Total number **not** in compliance with requirement		
	Percent out of compliance	%	
5b.	Is the MHP notifying beneficiaries of the appeal disposition and is this being documented?		
	Total number of appeals reviewed		
	Total number in compliance with requirement		
	Total number **not** in compliance with requirement		
	Percent out of compliance	%	
5c.	Is the MHP notifying beneficiaries of the expedited appeal disposition and is this being documented?		
	Total number of expedited appeals reviewed		
	Total number in compliance with requirement		
	Total number **not** in compliance with requirement		
	Percent out of compliance	%	

6. 6a.	Does the written notice of the appeal resolution include the following? The results of the resolution process and the date it was completed.			**NOTE:** "Notice" refers to notice of disposition to beneficiaries or their representatives.
6b.	For appeals, if beneficiary is dissatisfied with the decision, the beneficiary has the right to request a State fair hearing, and how to do so.			**NOTE:** DMH Letter No. 05-03 states; Effective July 1, 2005, beneficiaries will be required to exhaust the MHP's problem resolution process prior to filing for a State fair hearing. • 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.

SECTION C BENEFICIARY PROTECTION

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
• *CFR, title 42, section 438.408l(1),(2)(as modified by the waiver renewal request of August, 2002 and CMS letter, August 22, 2003)* • *CCR, title 9, chapter 11, section 1850.207(h)(3)* • *DMH Letter No. 05-03*				**OUT OF COMPLIANCE:** • The written notice does not include requirements 6a and 6b.
7.	Is the MHP notifying those providers cited by the beneficiary or otherwise involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal or expedited appeal?			• How are the providers notified? • Review evidence of provider notification.
• *CCR, title 9, chapter 11, section 1850.205(d)(6)*				**OUT OF COMPLIANCE:** • The MHP is not notifying the provider of the grievance, appeal or expedited appeal disposition.
8.	Does the MHP ensure services are continued while an appeal or State fair hearing is pending?			**NOTE:** Beneficiaries must have met Aid Paid Pending (APP) criteria per CCR, title 22, section 51014.2 (e.g. made a request for an appeal within 10 days of the date the NOA was mailed or given to the beneficiary or, if the effective date of the change is more than 10 days from the NOA date, before the effective date of the change).

SECTION C BENEFICIARY PROTECTION

CRITERIA	IN COMPLIANCE Y N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
• *CFR, title 42, section 438.420 (as modified by the waiver renewal request of August, 2002 and CMS letter, August 22, 2003)* • *CCR, title 9, chapter 11, section 1850.215* • *CCR, title 22, section 51014.2* • *DMH Letter No. 05-03*		**OUT OF COMPLIANCE:** • When APP criteria have been met, the MHP is not continuing SMHS as required.

SECTION D FUNDING, REPORTING, AND CONTRACTING REQUIREMENTS

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
MAINTENANCE OF EFFORT (MOE)				
1.	Regarding the MOE requirements, is the county in compliance with either 1a or 1b?			**NOTE:** Interview MHP fiscal officer. • Refer to MOE dollar amount requirements as noted within DMH Information Notice 95-13 and DMH Information Notice 97-05. • Obtain from county the recent quarterly county submission reports to the State Controller's Office for FY 2013-2014.
1a.	Is the county depositing its local matching funds per the schedule developed by the Department?			
1b.	If the county elects not to apply MOE funds, is the county in compliance with W&IC, section 17608.05I that prohibits the county from using the loss of these funds for realignment purposes?			
• *W&IC, sections 5614(b)(1), 17608.05(a),(b),(c), and 17609.05* • *DMH Information Notices No. 97-05 and No. 95-13*		**OUT OF COMPLIANCE:** • The county is not depositing its local matching funds per schedule. • The county is not in compliance with W&IC, section 17608.05I.		
FUNDING OF CHILDREN'S SERVICES				
2.	Is the county in compliance with either 2a or 2b?			**NOTE:** Interview MHP fiscal officer. • Obtain verification from the county.
2a.	The requirement to maintain its funding for children's services at a level equal to or more than the proportion expended for children's services in FY 83-84.			

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
2b.	The requirement to document the determination in a noticed public hearing that the need for new or expanded services to persons under 18 has significantly decreased.			**NOTE:** Public hearing is the Board of Supervisors meeting. • If proportion has decreased significantly, review documentation from public hearing.
• *W&IC, sections 5704.5 (b), 5704.6 (c), and 5614 (b)(3)*				**OUT OF COMPLIANCE:** • The county does not maintain funding for children's services per requirement. • The county does not have documentation from a noticed public hearing.
3.	Is the county in compliance? The requirement to 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.			**NOTE:** Interview MHP fiscal officer. • Obtain verification from the county.
• *W&IC, sections 5704.6(a),(c) and 5614(b)(3)*				**OUT OF COMPLIANCE:** • The county does not allocate funding for children's services per requirement. • The county does not have documentation from a noticed public hearing.

SECTION E TARGET POPULATIONS AND ARRAY OF SERVICES

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
BRONZAN – MCCORQUODALE ACT NON MEDI-CAL SERVICES				
1. 1a.	Regarding program principles and the array of treatment options required under W&IC, sections 5600.2 to 5600.9 inclusive: To the extent resources are available, are services encouraged in every geographic area and are the services to the target populations planned and delivered so as to ensure access by members of the target populations, including all ethnic groups in the state?			**NOTE:** Program principles include: § 5600.2. Health care systems; target populations; factors § 5600.3. Mental health account funds; populations targeted for use § 5600.35. Statewide access to services § 5600.4. Treatment options § 5600.5. Children and youth in target population; minimum array of services § 5600.6. Adults in target population; minimum array of services § 5600.7. Older adults in target population; minimum array of services § 5600.8. Allocation of funds § 5600.9. Planning and delivery of services
1b.	To the extent resources are available, is the county organized to provide an array of treatment options in every geographic area to the target population categories as described in W&IC, section 5600.3, including all ethnic groups?			**NOTE:** Treatment options include: Pre-crisis and Crisis Services Comprehensive Evaluation and Assessment Individual Service Plan Medication Education and Management Case Management 24/7 Treatment Services Rehabilitation and Support Services Vocational Rehabilitation Residential Services Services for Persons who are Homeless Group Services

SECTION E TARGET POPULATIONS AND ARRAY OF SERVICES

	IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
CRITERIA	**Y**	**N**	**COMMENTS**
• *W&IC, sections 5600.2 to 5600.9, 5600.35(a), and 5614*			**OUT OF COMPLIANCE:** • To the extent resources are available; evidence the county is not maintaining the program principles as required under W&IC regulations. • To the extent resources are available, evidence the county is not organized to provide an array of treatment options in every geographic area to the target population categories as described in the W&IC regulations.

SECTION E TARGET POPULATIONS AND ARRAY OF SERVICES

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES				
2.	Is the county organized to provide the Specialty Mental Health Services as listed in accordance with CCR, title 9, chapter 11, section 1810.247?			**NOTE:** CCR, title 9, chapter 11, section 1810.247. Specialty Mental Health Services means: (a) Rehabilitative Mental Health Services, including: (1) Mental health services; (2) Medication support services; (3) Day treatment intensive; (4) Day rehabilitation; (5) Crisis intervention; (6) Crisis stabilization; (7) Adult residential treatment services; (8) Crisis residential treatment services; (9) Psychiatric health facility services; (b) Psychiatric Inpatient Hospital Services; (c) Targeted Case Management; (d) Psychiatrist Services; (e) Psychologist Services; (f) EPSDT Supplemental Specialty Mental Health Services; and (g) Psychiatric Nursing Facility Services.
• *CCR, title 9, chapter 11, section 1810.247* • *W&IC, section 14680*		**OUT OF COMPLIANCE:** • The county is not organized to provide SMHS listed in accordance with CCR, title 9, chapter 11, section 1810.247.		

SECTION F INTERFACE WITH PHYSICAL HEALTH CARE

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
RE: RELATIONSHIP WITH PHYSICAL HEALTH CARE PROVIDERS WHO DO NOT BELONG TO A MEDI-CAL MANAGED CARE PLAN				
1.	Regarding coordination with: A. Primary Care Physicians (PCPs) when no Medi-Cal Managed Care Plans are present B. PCPs who do not belong to a Medi-Cal Managed Care Plan C. Federally Qualified Health Centers, Indian Health Centers, or Rural Health Clinics			**<u>The following information applies to items 1a-b</u>:** CCR, title 9, chapter 11, section 1810.415(a) states: 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 treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving specialty mental health services from the MHP.
1a.	Are the following conditions being met? Does the MHP have a process in place to provide clinical consultation and training, including consultation and training on medications?			• Ask the MHP to describe the processes in place for 1a-b. • Review the MHP's policies and procedures. • Verify processes in practice for 1a-b.
1b.	Does the MHP have a process in place for the exchange of medical record information that maintains confidentiality in accordance with applicable State and federal laws and regulations?			• Review Confidentiality/HIPAA policies and forms, including Authorization for Release of Information forms.
• *CFR, title 42, Part 438, section 438.208* • *DMH Information Notice No. 97-06* • *CCR title 9, chapter 11, section 1810.415(a),(b),(c)*		**<u>OUT OF COMPLIANCE</u>:** • There are no processes in place for 1a-b.		

SECTION G PROVIDER RELATIONS

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
1.	Does the MHP have an ongoing monitoring system in place that ensures all contracted individual, group, and organizational providers utilized by the MHP are in compliance with the documentation standards requirements as per title 9 regulations?			**NOTE:** Monitoring of contracted individual, group, and organizational providers may be by way of the contract/written agreements with these providers. • Review the evidence of how the MHP monitors the individual, group and organizational providers to ensure documentation standards are being met. • Review MHP monitoring activities of documentation standards.
• *CCR, title 9, chapter 11, sections 1810.110(a), 1810.435(a)(b)(4) and (c)(7), 1840.112, and 1840.314*				**OUT OF COMPLIANCE:** • The MHP does not have a monitoring system in place. • The MHP has no documentation of monitoring activities.
2.	Does the MHP have an ongoing monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified as per title 9 regulations?			• Check dates on a sample of certifications and re-certifications to determine compliance. • DHCS to review provider information and identify overdue re-certifications prior to the onsite review.
• *CCR, title 9, chapter 11, section 1810.435 (d)I* • *MHP Contract, Exhibit A, Attachment I*				**OUT OF COMPLIANCE:** • The MHP does not have a monitoring system in place. • The MHP is not following certification and recertification requirements as per title 9 regulations. • Re-certifications are overdue

CRITERIA		IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
Provider Relations - Certifications / Recertifications				
Total number of MHP active providers (mode 18)				
Number of providers currently overdue for recertification				
Percentage of providers currently overdue for recertification				%
3.	Does the MHP maintain and monitor a network of appropriate providers that is supported by written agreements that consider the following:			**<u>The following information applies to items 3a-e:</u>** **<u>NOTE</u>:** "Network" includes all providers (individual, group, and organizational), including county and contract providers.
3a.	In establishing and maintaining the network, did the MHP consider the anticipated number of Medi-Cal eligible clients?			• Written agreement means MHP written contracts with its individual, group, and organizational providers. • Review evidence of the MHP analysis of factors 3a-e. • Are changes being made based on analysis?
3b.	The expected utilization of services?			
3c.	The number and types of providers in terms of training, experience and specialization needed to meet expected utilization?			
3d.	The number of network providers who are not accepting new beneficiaries?			
3e.	The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries and physical access for disabled beneficiaries?			
• *CFR, title 42, section 438.206(b)(1)* • *CCR, title 9, chapter 11, section 1810.310 (a)(5)(B)* • *MHP Contract, Exhibit A, Attachment I* • *CMS/DHCS, section 1915(b) waiver*				**<u>OUT OF COMPLIANCE</u>:** • The MHP is not maintaining and monitoring the network of providers that is supported by written agreements. • The MHP in establishing and maintaining the network did not consider the factors listed in 3a-e as per title 9 and title 42 regulations.

SECTION G PROVIDER RELATIONS

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
Documentation: List documents reviewed that demonstrate compliance and provides specific explanation of reason(s) for in compliance or out of compliance.				
4. 4a.	Regarding the MHP's network providers, does the MHP ensure the following: Providers ensure timely access to care and services, taking into account the urgency of need for services?			**The following information applies to items 4a-f:** **NOTE:** How is the MHP monitoring and ensuring 4a-f? 24/7 Access to urgent and emergency services 24/7 toll-free telephone number • MHP standards for providers as indicated in written agreements with its providers • Review a sample of provider contracts to verify contract standards are being met (e.g. timeline for first appointment).
4b.	Providers offer hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service, if the provider serves only Medicaid beneficiaries?			**NOTE:** This applies at the contract provider level. • There should be no language that discriminates against Medi-Cal beneficiaries (e.g. appointment times limited to specific hours of the day/week).
4c.	Services are available to beneficiaries 24/7 when medically necessary?			**NOTE:** This applies to network providers, not each individual provider.
4d.	Mechanisms have been established to ensure that network providers comply with the timely access requirements?			• What mechanisms does the MHP have in place to ensure compliance?
4e.	Providers are regularly monitored to determine compliance with timely access requirements?			• Review MHP provider monitoring process and tools. • Review MHP monitoring results.

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
4f.	Corrective action is taken if there is a failure to comply with timely access requirements?			• Verify evidence that the MHP has a process in place when corrective action is needed. • Identify process and corrective action. • Review a random sample of provider corrective actions issued during the triennial review period.
• *CFR, title 42, section 438.206I(1)(i)* • *MHP Contract, Exhibit A, Attachment I*		**OUT OF COMPLIANCE:** • The MHP is not monitoring its provider network to ensure compliance with the requirements of a-f as per title 42 regulations.		

SECTION H PROGRAM INTEGRITY

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
1. 1a.	Regarding Program Integrity Requirements, does the MHP have the following in place? A mandatory compliance plan that is designed to guard against fraud and abuse.			**The following information applies to items 1a-h:** • Review MHP Compliance Plan and identify all required elements are present. • Review MHP written administrative and management policies and procedures, and standards of conduct.
1b.	Written P&Ps and standards of conduct that articulate the organization's commitment to comply with all applicable federal and State standards.			• Review MHPs written P&Ps and standards of conduct for evidence of 1b – 1d.
1c.	The designation of a compliance officer that is accountable to senior management.			
1d.	The designation of a compliance committee that is accountable to senior management			
1e.	Training and education for the compliance officer.			• Review evidence of training and education for compliance officer.
1f.	Training and education for the organization's employees?			• Review evidence of compliance training and education for employees.
1g.	Effective lines of communication between the compliance officer and the organization's employees.			• Review examples of communication ie.,newsletters; memos, postings, etc.
1h.	Enforcement of the standards through well publicized disciplinary guidelines.			• Review evidence of disciplinary guidelines and how MHP will enforce those standards.
1i.	Provision for internal monitoring and auditing.			• Review monitoring, auditing, policies and procedures.

SECTION H PROGRAM INTEGRITY

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
1j.	Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MHP's Contract.			• Review evidence of prompt response for detected offenses and corrective action plans.
• *CFR, title 42, sections 438.10, 438.604, 438.606, 438.608 and 438.610* • *MHP Contract, Exhibit A, Attachment I*		**OUT OF COMPLIANCE:** • The County/MHP does not have written P&Ps on each of the required elements. • The MHP does not meet the required Program Integrity Requirements.		
2. 2a.	Regarding the MHP's compliance with the Program Integrity requirements, does the MHP ensure the following: Does the MHP have a method to verify whether services reimbursed by Medicaid were actually furnished to the beneficiaries?			**NOTE:** Refer to MHP Contract, Program Integrity Requirements. Pursuant to title 42, CFR, section 455.1(a)(2), the Contractor shall 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 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*. • Review MHPs policies and procedures. • MHP to provide documented evidence regarding their findings and actions taken. • Review tracking documents or logs. • 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 that services reimbursed by Medicaid/Medi-Cal that were not received by the beneficiary were recouped.
2b.	What were the findings and what actions were taken by the MHP upon discovery that services reimbursed by Medicaid were not received by the beneficiaries?			

SECTION H PROGRAM INTEGRITY

CRITERIA	IN COMPLIANCE Y N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
• *CFR, title 42, sections 455.1(a)(2) and 455.20 (a)* • *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements* • *Social Security Act, Subpart A, Sections 1902(a)(4), 1903(i)(2) and 1909*	**OUT OF COMPLIANCE:** • The MHP does not have policies/procedures in place to verify and track beneficiary receipt of services • MHP not in compliance with regulatory and contractual requirements regarding Program Integrity Requirements, Service Verification. • No appropriate actions taken by MHP upon discovery that services reimbursed by Medicaid/Medi-Cal were actually furnished to the recipients. • Implementation of needed system changes not taking place. • The MHP does not have a method to verify with the beneficiary that services reimbursed by Medicaid/Medi-Cal were received.	

SECTION H **PROGRAM INTEGRITY**

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
3.	Does the MHP ensure that it captures the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents as required in CFR, title 42, sections 455.101 and 455.104 and in the MHP Contract, Program Integrity Requirements?			• MHP to provide written verification of compliance with CFR, title 42, sections 455.101 and 455.104 and the MHP Program Integrity Requirements. • Review MHP contracted service provider contracts; Disclosure of 5% or More Ownership Interest. 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, Contractor will make the disclosures set forth in i subsection 2(a). • 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. • Contracted providers of the MHP are responsible to disclose this information to the MHP.
• *CFR, title 42, sections 455.101 and 455.104* • *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements*		**OUT OF COMPLIANCE:** • No evidence that the MHP ensures that any of the entities ranging from providers, managing employees, agents, and managing agents in the MHP require disclosure of ownership, control, and relationship information. • MHP not in compliance with CFR regulations and with regulatory and contractual requirements regarding Program Integrity Requirements, Disclosure of ownership, control and relationship information.		

SECTION H **PROGRAM INTEGRITY**

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
4. 4a.	Does the MHP ensure the following requirements are met: Is there evidence that the MHP has a process in place to verify new and current providers and contractors are not on the Office of Inspector General Exclusion List and Medi-Cal List of Suspended or Ineligible Providers?			**NOTE:** The MHP does not employ or contract with providers excluded from participation in Federal health care programs under CFR, title 42, section 1128 or section 1128A of the Social Security Act or CFR, title 42, section 438.214. **NOTE:** Verify the List of Excluded Individuals/Entities: http://oig.hhs.gov/exclusions/exclusions_list.asp and https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp • 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 the written policies and procedures.
4b.	When an excluded provider/contractor is identified by the MHP, what action(s) is taken by the MHP?			• Review the MHP documentation of the identification of the excluded provider and action taken by the MHP. • The action taken must include the immediate cessation and prevention of the filing of claims for services rendered by the excluded provider.
• *CFR, title 42, sections 1128 and 1128A, Social Security Act* • *CFR, title 42, sections 438.214(d) and 438.610* • *DMH Letter No. 10-05* • *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements* • *CMS/DHCS, section 1915(b) waiver*				**OUT OF COMPLIANCE:** • There is no verification that the MHP ensures their new and current providers and contractors are not on the Excluded Provider List(s). • There is no evidence that the MHP has taken immediate action, as required in Title 42, in response to identifying a provider was on the Excluded Provider List(s).

SECTION I QUALITY IMPROVEMENT

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
1. 1a.	Is the QIC involved in or overseeing the following QI activities: Recommending policy decisions?			**NOTE:** Review QIC meeting minutes regarding decisions and actions taken.
1b.	Reviewing and evaluating the results of QI activities?			
1c.	Instituting needed QI actions?			
1d.	Ensuring follow-up of QI processes?			
1e.	Documenting QI committee meeting minutes?			
• *CCR, title 9, chapter 11, section 1810.440* • *MHP Contract, Exhibit A, Attachment I*		**OUT OF COMPLIANCE:** • There is no evidence that the QIC is involved in and overseeing activities described in 1a-e.		
2. .	Regarding the annual QI Work Plan: Does the MHP evaluate the effectiveness of the QI program and show how QI activities have contributed to improvement in clinical care and beneficiary service?			**NOTE:** Review QI Work Plan with documented annual evaluations and documented revisions as needed.
• *CCR, title 9, chapter 11, section 1810.440* • *MHP Contract, Exhibit A, Attachment I* • *CMS/DHCS, section 1915(b) waiver*		**OUT OF COMPLIANCE:** • The work plan does not evaluate the effectiveness of the QI program and show how QI activities have contributed to improvement in clinical care and beneficiary service. • The MHP does not have a QI Work Plan that meets regulatory and contractual requirements.		

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
3.	Does the QI Work Plan monitor previously identified issues, including tracking of issues over time?			**NOTE:** Review the current QI Work Plan, annual evaluations, QIC minutes. • Have the MHP describe activities and monitoring of previously identified issues. • Review evidence of the monitoring and evaluation • Are issues being identified, discussed and resolved over time in the QI work plan and/or the work plan evaluation?
• *CCR, title 9, chapter 11, section 1810.440* • *MHP Contract, Exhibit A, Attachment I*		**OUT OF COMPLIANCE:** • The work plan and/or work plan evaluation does not evaluate the effectiveness of the QI program and show how QI activities have contributed to improvement in clinical care and beneficiary service. • The MHP does not have a current QI Work Plan in place or is not following the QI Work Plan. • There is no evidence of identifying issues, monitoring or tracking activities over time.		
4. 4a.	Does the QI Work Plan include assessing the service delivery capacity of the MHP as evidenced by: 1. Monitoring the current number of mental health services within the MHP's delivery system?			**The following information applies to items 4a-c:** **NOTE:** MHP should have baseline statistics with goals for the year, as well as, annual evaluations and updates.
	2. Monitoring the types of mental health services within the MHP's delivery system?			
	3. Monitoring the geographic distribution of mental health services within the MHP's delivery system?			

SECTION I QUALITY IMPROVEMENT

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
4b.	1. Are goals set for the number of mental health services?			**NOTE:** • Goals should be set for 4b (1-3).
	2. Are goals set for the type of mental health services?			
	3. Are goals set for the geographic distribution of mental health services?			
4c.	Goals have been set and mechanisms have been established to monitor the following: 1. Timeliness of routine mental health appointments.			**NOTE:** Review P&Ps. • Goals should be set for 4c (1-4). • Mechanisms for monitoring should be in place for 4c (1-4).
	2. Timeliness of services for urgent conditions.			
	3. Access to after-hours care.			
	4. Responsiveness of the 24/7 toll-free number.			
5. 5a.	The MHP shall implement mechanisms to assess beneficiary/family satisfaction as evidenced by: Surveying beneficiary/family satisfaction with the contractor's services at least annually.			**The following information applies to items 5a-d:** • Review evidence that surveys were provided/conducted in all threshold languages. • Activities related to beneficiary satisfaction can include surveys, outreach, education, focus groups, and other related activities. • Refer to current EQRO report regarding consumer satisfaction survey, if applicable.
5b.	Evaluating beneficiary grievances, appeals, and fair hearings at least annually.			

SECTION I **QUALITY IMPROVEMENT**

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
5c.	Evaluating requests for changing persons providing services at least annually.			
5d.	Informing providers of the results of the beneficiary/family satisfaction activities.			
6.	Is the MHP monitoring the safety and effectiveness of medication practices at least annually?			**NOTE**: The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.
7.	Interventions implemented by MHP when quality of care concerns are identified.			• Review evidence of appropriate follow-up activities.
8.	Does the MHP QI program include active participation by the Contractor's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the QI program?			• Describe and review the evidence of involvement of providers, beneficiaries and family members in evaluating data, and state the outcomes.
9.	Monitoring provider appeals as per title 9 regulations?			**NOTE:** CCR, title 9, chapter 11, section 1810.440(a)(5) requires that the MHP QI program conduct 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.
• *CCR, title 9, chapter 11, section 1810.440(a)(5)* • *DMH Information Notice No. 10-17, Enclosures, Pages 18 & 19, and DMH Information Notice No. 10-02, Enclosure, Page 23* • *CFR, title 42, Part 438-Managed Care, sections 438.204, 438.240 and 438.358.* • *MHP Contract, Exhibit A, Attachment I*				**OUT OF COMPLIANCE:** • No current QI Work Plan in place. • Not following the QI Work Plan. • There is no evidence of required monitoring activity.

SECTION J MENTAL HEALTH SERVICES ACT (MHSA)

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
1. 1a.	W&IC 5847 requires County mental health programs to prepare and submit a three-year program and expenditure plan. The plan shall be developed through a meaningful stakeholder process which includes a public comment period and public hearing. Is there evidence that the County circulated a draft plan and update for public review and comment for at least 30 calendar days?			• The County shall provide evidence of circulation methods, posting date, and 30 day public comment period. • The County shall provide evidence of a public hearing at the close of the 30 day comment period. • DHCS Compliance staff to obtain information directly from the MHP. • The MHP shall provide documentation of where and when the draft plan was posted (i.e., a copy of a website page with the date of the posting, copy of the public notice and evidence of the 30 day public comment period.
1b.	Is there evidence that the mental health board conducts a public hearing at the close of the 30 day public comment period?			• The MHP shall provide documentation of substantial stakeholder comments as reflected in: o Board minutes and agenda o Public comment cards and/or o Summary of public hearing comments
1c.	Did the MHP stakeholder process meet the requirements of CCR, title 9, section 3200.270?			"Stakeholders" means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families.

SECTION J MENTAL HEALTH SERVICES ACT (MHSA)

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
• *W&IC 5847* • *W&IC 5848(a)* • *W&IC 5848(b)* • *CCR, title 9, section 3315 and section 3200.270*				**OUT OF COMPLIANCE:** • County has not completed a 30 day comment period. • County has not conducted a hearing at the end of the comment period. • Stakeholder process did not meet Title 9 requirements.
2.	County Performance Contracts require that Counties adopt an Issue Resolution Process in order to resolve issues related to the MHSA community planning process, consistency between approved MHSA plans and program implementation, and the provision of MHSA funded mental health services. Counties are required to keep and update an Issue Resolution Log to handle client disputes and complaints. Does the County's Issue Resolution Log contain the following information:			**NOTE:** • The County shall provide evidence of an Issue Resolution Log. The Issue Resolution Log may reflect all grievances, regardless of program type. • The County shall provide descriptions and dates of initial issues and the issue resolution descriptions and dates. • DHCS Compliance staff to obtain information directly from the County.
2a.	Dates the issues were received and brief descriptions of the issues?			
2b.	Final resolution outcomes of those issues and dates they were resolved?			
• *W&IC 5650* • *W&IC 5651- The county performance contract contains the provision.*				**OUT OF COMPLIANCE:** • County does not keep an Issue Resolution Log. • County did not include dates, explanation of issues, outcomes, or dates of outcomes.

SECTION K CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
Documentation: List documents reviewed that demonstrate compliance and provides specific explanation of reason(s) for in compliance or out of compliance.				
RE: MEDICAL NECESSITY				
1. 1a.	Does the beneficiary meet all three (3) of the following medical necessity criteria for reimbursement (1a, 1b, and 1c. below)? The beneficiary has a DSM diagnosis contained in the CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R).			**NOTE:** Review assessment(s), evaluation(s), and/or other documentation to support 1a-1c. • Is the beneficiary's diagnosis included in the list of diagnoses in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R).
1b.	The beneficiary, as a result of a mental disorder listed in 1a, must have, at least, one (1) of the following criteria (1-4 below): 1) A significant impairment in an important area of life functioning. 2) A probability of significant deterioration in an important area of life functioning. 3) A probability that the child will not progress developmentally as individually appropriate. 4) For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder that SMHS can correct or ameliorate.			**NOTE:** Refer to CCR, title 9, chapter 11, sections 1830.205 (b)(2)(A-C) and 1830.210. • Is there documentation that supports that the beneficiary, as a result of a mental disorder listed in CCR, title 9, chapter 1, section 1830.205(b)(1)(A-R) has met, at least, one (1) of the criteria listed in 1b.

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
1c.	Must meet each of the intervention criteria listed below: 1) The focus of the proposed intervention is to address the condition identified in No. 1b. (1-3) above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder that SMHS can correct or ameliorate per No. 1b. (4). 2) The expectation is that the proposed intervention 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.			Does the proposed intervention(s) focus on the condition(s) identified in No. 1b (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.1b (4)? • Is there a connection between the proposed intervention and one (1) of the following: A. Diminishing the impairment? B. Preventing a significant deterioration? C. Allowing a child to progress developmentally as individually appropriate? D. Correcting or ameliorating the condition?

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
	• *CCR, title 9, chapter 11, section 1830.205 (b)(c)* • *CCR, title 9, chapter 11, section1830.210* • *CCR, title 9, chapter 11, section 1810.345(c)* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)* • *CCR, title 22, chapter 3, section 51303(a)*			**OUT OF COMPLIANCE:** • Criteria 1a-c not supported by documentation. • No connection is identified between the functional impairment as it relates to the diagnosis and the service(s) provided. • No evidence that the intervention(s) provided met the intervention criteria listed in 1c.
	RE: ASSESSMENT			
2. 2a. 2b.	Regarding the Assessment, are the following conditions met: Has the Assessment been completed in accordance with regulatory and contractual requirements? Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness and frequency?			• Review the MHP's written documentation standards guidelines. • Review assessment(s), evaluation(s), and/or other documentation to support 1a, 1b, and 1c. • Review the prior and current assessment for timeliness and frequency. **NOTE:** The MHP shall establish written standards for timeliness and frequency for the required assessment elements identified in 2c. (Refer to the MHP Contract, Exhibit A, Attachment I)

	CRITERIA	IN COMPLIANCE Y	N	COMMENTS	*INSTRUCTIONS TO REVIEWERS*
2c.	Does the Assessment include the areas specified in the MHP Contract with the Department? 1) Presenting Problem. The beneficiary's chief complaint, history of presenting problem(s), including current level of functioning, relevant family history and current family information; 2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma; 3) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports; 4) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;				• Review for the required appropriate elements. These elements may include but not limited to the following: a) Presenting Problem b) Relevant conditions and psychosocial factors c) Mental Health History d) Medical History

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
	5) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications; 6) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs; 7) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis; 8) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma; 9) A mental status examination; 10) A complete five-axis diagnosis from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and, 11) Additional clarifying formulation information, as needed.			• Review for the required appropriate elements. These elements may include but not limited to the following (continued): e) Medications f) Substance Exposure/Substance Use g) Client Strengths h) Risks i) A mental status examination j) A complete five-axis diagnosis k) Additional clarifying formulation information, as needed

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
2d. 2e.	Did the provider obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of psychiatric medication? Did the documentation include, but not limited to: 1) The reasons for taking such medications; 2) Reasonable alternative treatments available, if any; 3) The type, range of frequency and amount, methods (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and 4) That the consent, once given, may be withdrawn at any time by the beneficiary.			• Review the medication orders and medication consents.
2f.	Is the documentation legible?			
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*		**OUT OF COMPLIANCE:** • No assessment has been completed. • The assessment or other documents in the medical record do not contain the required elements. • Medication consent requirements not met. • Documentation that is illegible.		

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
RE: CLIENT PLAN				
3.	Regarding the client plan, are the following conditions met:			**NOTE:** Coordinate findings with the System Review process. • Review the MHP's written documentation standards guidelines.
3a.	Has the client plan been completed in accordance with regulatory and contractual requirements?			
3b.	as the client plan been updated at least annually, or when there are significant changes in the beneficiary's condition?			Review the prior and current client plans for timeliness and frequency.
3c.	Does the client plan include the items specified in the MHP Contract with the Department? 1) Specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.			**NOTE:** Coordinate findings with the System Review process. view the objectives and interventions of the client plan for compliance as indicated in 3c (1-6).
	2) The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.			
	3) The proposed frequency and duration of intervention(s).			
	4) Interventions that focus and address the identified functional impairments as a result of the mental disorder.			
	5) Interventions that are consistent with client plan goal(s)/treatment objective(s).			
	6) Be consistent with the qualifying diagnoses.			

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
3d.	Is the client plan signed (or electronic equivalent) by 1) The person providing the service(s) or, 2) A person representing a team or program providing the service(s) or, 3) A person representing the MHP providing service(s) or, 4) By one of the following as a co-signer, if the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is <u>not</u> of the approved categories, one (1) of the following must sign: A. A Physician B. A Licensed/Waivered Psychologist C. A Licensed/Registered/Waivered Social Worker D. A Licensed/Registered/Waivered Marriage and Family Therapist E. A Licensed/Registered/Waivered Professional Clinical Counselor* F. A Registered Nurse, including but not limited to nurse practitioners, and clinical nurse specialists			

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS / COMMENTS
	Is there documentation of the beneficiary's degree of participation and agreement with the client plan as evidenced by, but not limited to: 1) Reference to the beneficiary's participation in and agreement in the body of the client plan; or 2) The beneficiary signature on the client plan; or 3) A description of the beneficiary's participation and agreement in the medical record. The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when: 1) The beneficiary is expected to be in long-term treatment, as determined by the MHP, and, 2) The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS. 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 shall include a written explanation of the refusal or unavailability.			• Review for the beneficiary's degree of participation and agreement with the plan as follows: A. 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. B. Whether or not the beneficiary signature is required: • Is the beneficiary expected to be in long-term treatment as determined by the MHP? • Will the beneficiary be receiving more than one type of Specialty Mental Health Services? • Is the beneficiary required to sign the client plan per the MHP's documentation standards guidelines? C. When the beneficiary's signature is required on the client plan and the beneficiary refuses or is unavailable for signature, is there a written explanation of the refusal or unavailability?
3f.	Does the MHP have a written definition of what constitutes a long-term care beneficiary?			• Review the MHP's written definition of a long-term care beneficiary.
3g.	Is there documentation that the contractor offered a copy of the client plan to the beneficiary?			• Review the medical record for documentation.

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
3h.	Is the documentation legible?			
• *CCR, title 9, chapter 11, section 1810.205.2* • *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *DMH Letter 02-01, Enclosure A* • *W&IC, section 5751.2* • *MHP Contract, Exhibit A, Attachment I* • *CCR, title 16, Section 1820.5* • *California Business and Profession Code, Section 4999.20*	**OUT OF COMPLIANCE:** • Requirements not met in 3a-3c. • Client plan was not completed. • Client plan was not updated at least annually and when there were significant changes in the beneficiary's condition. • Client plan was not signed by staff as indicated in 3d. • No evidence that the contractor offered a copy of the client plan to the beneficiary. • No evidence of the beneficiary agreeing or participating in the client plan. • Client plan was not signed by the beneficiary when required. • No written explanation when the beneficiary refuses to sign or is unavailable. • No written definition of what constitutes a long-term care beneficiary. • Documentation that is illegible.			

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS / COMMENTS
RE: PROGRESS NOTES				
4. 4a. 4b.	Do the progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan? Do the progress notes document the following? 1) Timely documentation of relevant aspects of client care, including documentation of medical necessity; 2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions; 3) Interventions applied, beneficiary's response to the interventions and the location of the interventions; 4) The date the services were provided; 5) Documentation of referrals to community resources and other agencies, when appropriate; 6) Documentation of follow-up care, or as appropriate, a discharge summary; and 7) The amount of time taken to provide services; 8) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable; and 9) The date the service was documented in the medical record by the person providing the service.			• Review the MHP's documentation standards guidelines. • Review the progress notes for: A. How services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. B. Timely documentation C. Medical necessity D. Beneficiary encounters and relevant clinical decisions E. Interventions applied, beneficiary's response to the interventions and the location of the interventions; F. The date the services were provided G. Documentation of referrals to community resources and other agencies, when appropriate; H. Documentation of follow-up care, or as appropriate, a discharge summary; I. Amount of time taken to provide services J. Signature of the person providing the service; the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable. K. The date the service was documented in the medical record by the person providing the service.

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
4c.	meliness/frequency as follows: 1) Every service contact for: A. Mental health services B. Medication support services C. Crisis intervention D. Targeted Case Management 2) Daily for: A. Crisis residential B. Crisis stabilization (one per 23/hour period) C. Day treatment intensive 3) Weekly for: A. Day treatment intensive (clinical summary) B. Day rehabilitation C. Adult residential			**NOTE:** Effective September 1, 2003, the day treatment intensive weekly clinical summary note must be reviewed and signed by one of the following: - Physician - Licensed/Waivered Psychologist - Licensed/Registered/Waivered Social Worker - Licensed/Registered/Waivered Marriage and Family Therapist - Licensed/Registered/Waivered Professional Clinical Counselor - Registered Nurse **NOTE:** Documentation must support the program requirements, the type of service, date of service and units of time claimed.
4d.	s the documentation legible?			
• *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* • *CCR, title 9, chapter 11, section 1840.314* • *CCR, title 9, chapter 11, sections 1840.316 - 1840.322* • *CCR, title 22, chapter 3, section 51458.1* • *CCR, title 22, chapter 3, section 51470* • *MHP Contract, Exhibit A, Attachment I* • *DMH Letter No. 03-03*			**OUT OF COMPLIANCE:** • Progress notes do not describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. • Progress notes that do not indicate the date of service, the amount of time and beneficiary encounters as specified in 4a - 4c. • Documentation that is illegible. • Services not documented timely. • No signature of person providing the services as specified in 4b (8). • Evidence that beneficiaries are not receiving services that were claimed.	
Documentation: List documents reviewed that demonstrate compliance and provides specific explanation of reason(s) for in compliance or out of compliance.				

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS / COMMENTS
RE: DAY TREATMENT INTENSIVE / DAY REHABILITATION				
5	Have *Day Treatment Intensive* and *Day Rehabilitation* services been provided in accordance with regulatory and contractual requirements?			**NOTE:** The MHP shall 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.*
5a.	**Service Components:** 1) Do *Day Treatment Intensive* and *Day Rehabilitation* programs include all the following required service components: A. Daily Community Meetings;* B. Therapeutic Milieu; C. Process Groups; D. Skill-building Groups; and E. Adjunctive Therapies? 2) In addition: A. Does *Day Treatment Intensive* include Psychotherapy?** **NOTE**:** Psychotherapy does not include physiological interventions, including medication intervention. **NOTE:** *Day Rehabilitation* may include psychotherapy instead of process groups, or in addition to process groups.			• 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 **NOTE*:** Community meetings must occur at least once a day and have the following staffing: A. For *Day Treatment Intensive*: Staff whose scope of practice includes psychotherapy B. For *Day Rehabilitation*: Staff who is a physician, licensed/waivered/registered psychologist, clinical social worker, marriage and family therapist, or professional clinical counselor, registered nurse, psychiatric technician, licensed vocational nurse, or mental health rehabilitation specialist

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
5b.	**Attendance:** 1) Is there documentation of the total number of minutes/hours the beneficiary actually attended the program? 2) If the beneficiary is unavoidably absent: A. Is the total time (number of hours and minutes) the beneficiary actually attended the program that day documented; B. Is the beneficiary present for at least 50 percent of the scheduled hours of operation for that day; and C. Is there a separate entry in the medical record documenting the reason for the unavoidable absence?			• Review the 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 in the medical record documenting the reason and the total minutes/hours of actual attendance. **NOTE:** Per the MHP Contract, Exhibit A, Attachment I, 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.
5c.	**Continuous Hours of Operation:** Did the provider apply the following when claiming for the continuous hours of operation of *Day Treatment Intensive* and *Day Rehabilitation* services? A. For Half Day: The beneficiary received face-to-face services a minimum of three (3) hours each day the program was open. B. For Full-Day: The beneficiary received face-to-face services in a program with services available more than four (4) hours per day.			• Review Written Weekly Schedule and other documentation to ensure this requirement is met. **NOTE:** 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.

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
5d.	**Staffing Requirements:** 1) Do *Day Treatment Intensive* and *Day Rehabilitation* meet the following staffing requirements: A. For *Day Treatment Intensive*: Psychotherapy is provided by licensed, registered, or waivered staff practicing within their scope of practice. B. For all scheduled hours of operation: There is at least one staff person present and available to the group in the therapeutic milieu.			• Review the Written Weekly Schedule, progress notes and other documentation to determine if the required and qualified staff were available for all scheduled hours of operation.
5e.	**Documentation Standards:** 1) Is the required documentation timeliness/frequency for *Day Treatment Intensive* or *Day Rehabilitation* being met? A. For *Day Treatment Intensive* services: • Daily progress notes on activities; and • A weekly clinical summary. B. For *Day Rehabilitation* services: • Weekly progress note. 2) Do 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?			• 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. **NOTE:** 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.

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
5f.	**Written Program Description:** 1) Is there a Written Program Description for *Day Treatment Intensive* and *Day Rehabilitation?* A. Does the Written Program Description describe the specific activities of each service and reflect each of the required components of the services as described in the MHP Contract. 2) Is there a Mental Health Crisis Protocol? *3)* Is there a Written Weekly Schedule? A. Does the Written Weekly Schedule: a) Identify when and where the service components will be provided and by whom; and *b)* Specify the program staff, their qualifications, and the scope of their services?			• Review the Written Program Description and Written Weekly Schedule to determine if: A. There are specific activities described for each service component. 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 was available for all scheduled hours of operation. **NOTE:** 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.

- *CCR, title 9, chapter 11, section 1810.212*
- *CCR, title 9, chapter 11, section 1810.213*
- *CCR, title 9, chapter 11, section 1840.112(b)*
- *CCR, title 9, chapter 11, section 1840.314(d)(e)*
- *CCR, title 9, chapter 11, section 1840.318*
- *CCR, title 9, chapter 11, section 1840.360*
- *MHP Contract, Exhibit A, Attachment I*
- *DMH Letter No. 03-03*

OUT OF COMPLIANCE:

- The service components for *Day Treatment Intensive* and *Day Rehabilitation* were not offered or provided; or were provided by staff outside their scope of practice.
- Staff not present as required in 5c.
- Beneficiary attendance requirements were not met.
- No documentation of the total number of minutes/hours the beneficiary actually attended the program.
- When unavoidably absent, no documentation of the reason and/or total number of minutes/hours of actual attendance.
- Scheduled hours of continuous operation requirements for *Day Treatment Intensive* and *Day Rehabilitation* were not met.
- No documentation of the date(s) of service, signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title, and/or date of signature.
- Daily progress notes and weekly clinical summary requirements were not met.
- Written Weekly Schedule or Written Program Description requirements were not met.

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
RE: OTHER MEDICAL RECORD DOCUMENTATION				
6.	Do all entries in the beneficiary's medical record include: 1) The date of service; 2) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable; AND 3) The date the documentation was entered in the medical record?			
	MHP Contract, Exhibit A, Attachment I	**OUT OF COMPLIANCE:** • Requirements not met in 6 (1-3)		
7.	When applicable, was information provided to beneficiaries in an alternative format?			**NOTE:** When applicable, review evidence beneficiaries were provided with information in an alternative format. Coordinate findings with the System Review process.
• *CFR, title 42, section 438.10(d)(2)* • *CCR, title 9, chapter 11, section 1810.410 (b)* • *DMH Information Notice No. 97-06, D, 5* • *MHP Contract, Exhibit A, Attachment I*	**OUT OF COMPLIANCE:** • There is no evidence that beneficiaries were provided with information in an alternative format.			

CRITERIA		IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
8. 8a.	Regarding cultural/linguistic services: Is there any evidence that mental health interpreter services are offered and provided, when applicable?			**The following information applies to items 8a-c:** • Review CCPR, MHP's policies and procedures and medical records for: A. 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. There is evidence beneficiaries are made aware that specialty mental health services are available in their preferred language. **NOTE:** Interpreter services mean oral and sign language. **NOTE:** Coordinate findings with the System Review process.
8b.	When applicable, is there documentation of linking beneficiaries to culture-specific and/or linguistic services as described in the MHP's CCPR?			
8c.	When applicable, is service-related personal correspondence provided in the beneficiary's preferred language?			
• *CFR, title 42, section 438.10(c)(4),(5)* • *CCR, title 9, chapter 11, section 1810.405(d)* • *CCR, title 9, section 1810.410* • *DMH Information Notice No. 10-02, Enclosures, Pages 22-23 and DMH Information Notice No. 10-17, Enclosures, Pages 17-18*				**OUT OF COMPLIANCE:** • No evidence of 8a-c.

SECTION L CHART REVIEW—SD/MC HOSPITAL SERVICES

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
RE: MEDICAL NECESSITY-ADMISSION, ACUTE AND CONTINUED STAY SERVICES				
1.	Does the beneficiary have a DSM diagnosis contained in the CCR, title 9, chapter 11, sections 1820.205(a)(1)(A) through 1820.205(a)(1)(R)?			Refer to CCR, title 9, chapter 11, section 1820.205 medical necessity criteria for reimbursement of Psychiatric Inpatient Hospital Services.
• *CCR, title 9, chapter 11, section 1820.205(a)(1)*		**OUT OF COMPLIANCE:** • Beneficiary does not have a DSM diagnosis from the included list in CCR, title 9, chapter 11, section 1820.205.		
2. 2a.	Did the beneficiary meet criteria in both 2a-2b. below: 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 shall be considered to have met this criterion?			**NOTE:** Review medical record documentation.
2b.	Required psychiatric inpatient hospital services, as the result of a mental disorder, due to indications in either (1) or (2) below: 1) Had symptoms or behaviors due to a mental disorder that (one of the following): a) Represented a current danger to self or others, or significant property destruction.			

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
	b) Prevented the beneficiary from providing for, or utilizing food, clothing or shelter.			
	c) Presented a severe risk to the beneficiary's physical health.			
	d) Represented a recent, significant deterioration in ability to function.			
	2) Required admission for one of the following:			
	a) Further psychiatric evaluation.			• The documentation must indicate why the "further psychiatric evaluation" can only be conducted on an inpatient psychiatric unit.
	b) Medication treatment.			• The documentation must indicate why the "medication treatment" can only be conducted on an inpatient psychiatric unit.
	c) Other treatment which could reasonably be provided only if the beneficiary were hospitalized.			
• *CCR, title 9, chapter 11, section 1820.205(a)(2)*		**<u>OUT OF COMPLIANCE</u>:** • Beneficiary does not meet criteria stated in 2a-2b.		
3.	Did the beneficiary's continued stay services in a psychiatric inpatient hospital meet one of the following reimbursement criteria 3a-3d:			• Review medical record documentation.
3a.	Continued presence of indications which meet the medical necessity criteria specified in items No. 2a-2b. above.			

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
3b.	Serious adverse reaction to medication, procedures, or therapies requiring continued hospitalization.			
3c.	Presence of new indications which met medical necessity criteria specified in items 2a and 2b just above.			
3d.	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, chapter 11, section 1820.205(b)*		**OUT OF COMPLIANCE:** • Documentation does not support medical necessity criteria.		

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
CRITERIA		**Y**	**N**	**COMMENTS**
RE: ADMINISTRATIVE DAY SERVICES				
4.	If payment has been authorized for administrative day services, were the following requirements met:			
4a.	During the hospital stay, did the beneficiary previously meet medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services?			
4b.	Was there no appropriate, non-acute treatment facility within a reasonable geographic area?			
4c.	Did the hospital document contacts with a minimum of five (5) appropriate, non-acute treatment facilities per week subject to the following requirements? 1) The lack of placement options at appropriate, non-acute residential treatment facilities and the contacts made at appropriate facilities shall 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, chapter 11, section 1820.220(5)(A),(B)*	**OUT OF COMPLIANCE:** • Documentation does not meet criteria for administrative day services.

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
RE: QUALITY OF CARE				
5. 5a.	Regarding culturally competent services: Is there any evidence that mental health interpreter services are offered?			**NOTE:** If beneficiary is LEP, review to determine whether interpretive services were offered. • Review medical record documentation. • Review inpatient IP.
5b.	When applicable, is there documentation of the response to offers of interpreter services as described in the MHP's CCPR?			
• *CCR, title 9, chapter 11, section 1810.410(a)* • *DMH Information Notice No. 10-02, Enclosure, Page 22 and DMH Information Notice No. 10-17, Enclosure, Page 17*				**OUT OF COMPLIANCE:** • NFP. • Documentation does not indicate that mental health interpreter services were offered. • The response not documented.
6.	Does the record documentation in the beneficiary's chart reflect 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?			**NOTE:** Use "Admission Summary Worksheet" and "Continued Stay Summary Worksheet." • Review medical record documentation. • Review MHP inpatient IP.
• *CCR, title 9, chapter 11, section 1810.310(a)(2)(A)* • *W&IC, section 4696.1*				**OUT OF COMPLIANCE:** • NFP. • Documentation does not reflect staff efforts for screening, referral, and coordination with other necessary services.

SECTION L CHART REVIEW—SD/MC HOSPITAL SERVICES

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
7.	Were services delivered by licensed staff within their own scope(s) of practice?			
W&IC Section 5778(n)		**OUT OF COMPLIANCE:** Evidence that staff is delivering services outside their scope of practice.		
8.	When applicable:			• As needed, review evidence that beneficiaries are provided information in an alternate format.
8a.	Is there evidence the MHP provided beneficiary protection material to beneficiaries in an alternate format when appropriate?			
8b.	Is service-related personal correspondence in the client's preferred language?			
• *CCR, title 9, chapter 11, section 1810.110(a)* • *DMH Information Notice Nos. 97-06 (paragraph D, 5 of the attachment), DMH Information Notice No. 10-02, Enclosure, Page 23, and DMH Information Notice No. 10-17, Enclosure, Pages 18-19* • *W&IC, sections 5600.2(e) and 5614(b)(5)*		**OUT OF COMPLIANCE:** • Where appropriate, no evidence that the beneficiary is provided with information in an alternate format. • Correspondence not in client's preferred language.		
9.	Does the MHP document in the individual's medical record whether or not the individual has executed an advance directive?			
• *CFR, title 42, sections 438.100(b)(1) and 417.436(d)(3)*		**OUT OF COMPLIANCE:** • Medical record does not document whether or not an advance directive has been executed.		

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
RE: PLAN OF CARE				
10. 10a.	Does the beneficiary have a written plan of care that includes the following elements: Diagnoses, symptoms, complaints, and complications indicating the need for admission?			• Review medical record documentation.
10b.	A description of the functional level of the beneficiary?			
10c.	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?			
10d.	Descriptions of the types of interventions/modalities, including a detailed description of the interventions to be provided?			
10e.	A proposed frequency and duration for each of the interventions?			
10f.	Interventions which are consistent with the qualifying diagnoses?			
10g.	Any orders for: 1) Medications? 2) Treatments? 3) Restorative and rehabilitative services? 4) Activities? 5) Therapies? 6) Social services?			

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
	7) Diet? 8) Special procedures recommended for the health and safety of the beneficiary?			
10h.	Plans for continuing care, including review and modification to the plan of care?			
10i.	Plans for discharge?			
10j.	Documentation of the beneficiary's degree of participation in and agreement with the plan?			**NOTE:** 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.
10k.	Documentation of the physician's establishment of the plan?			**NOTE:** Look for physician's signature.
• *CFR, title 42, section 456*.180 • *CCR, title 9, chapter 11, section 1820.210*		**OUT OF COMPLIANCE:** • Required elements are not documented.		

SECTION M— UTILIZATION REVIEW-SD/MC HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
1. 1a.	Does the Utilization Review (UR) Plan: Provide for a committee to perform UR?			**NOTE:** Review IP, MHP UR Plan, and Utilization Review Committee (URC) minutes. • Identify URC members. • Look at licenses of members.
1b.	Describe the organization, composition, and functions of the committee?			
1c.	Specify the frequency of the committee meetings?			• Are URC meetings held at the frequency specified?
• *CFR, title 42, section 456.201-205* • *CCR, title 9, chapter 11, section* 1820.210		**OUT OF COMPLIANCE:** • UR Plan does not provide a committee to perform UR. • URC does not describe the organization, composition, and functions. • URC meetings not held according to stated frequency. • URC does not have two physicians.		
2. 2a.	Does the UR plan provide that each recipient's record includes at least, the required information: Identification of the recipient?			• Review UR plan to determine if the required information is present. • Do the medical records include all of the required information.
2b.	The name of the recipient's physician?			
2c.	The date of admission?			
2d.	The plan of care required under CFR 456.180?			
2e.	Initial and subsequent continued stay review dates described under CFR 456.233 and 456.234?			
2f.	Reasons and plan for continued stay, if the attending physician believes continued stay is necessary?			

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
2g.	Other supporting material that the committee believes appropriate to be included in the record?			
• *CFR, title 42, sections 456.211, 456.233 and 456.234* • *CCR, title 9, chapter 11, section 1820.210*				**OUT OF COMPLIANCE:** • UR records do not include all of the required information. • The UR plan does not include all of the required review elements.
3. 3a.	Does the UR plan provide for a review of each recipient's continued stay in the mental hospital to decide whether it is needed and does it include the following: Determination of need for continued stay?			**NOTE:** 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?
3b.	Evaluation criteria for continued stay?			**NOTE:** Is the evaluation criteria documented?
3c.	Initial continued stay review date?			**NOTE:** Are the dates written?
3d.	Subsequent continued stay review dates?			
3e.	Description of methods and criteria for continued stay review dates; length of stay modification?			**NOTE:** Are the methods and criteria for documentation described? • Do the methods include a description of how the length of stay may be modified?
3f.	Continued stay review process?			**NOTE:** Is the continued stay review process documented?
3g.	Notification of adverse decision?			**NOTE:** Is the notification of adverse decision documented?

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
3h.	Time limits for final decision and notification of adverse decision?			**NOTE:** Are time limits for final decisions adhered to?
• *CFR, title 42, section 456.231-238* • *CCR, title 9, chapter 11, section 1820.210*				**OUT OF COMPLIANCE:** • NFP. • UR plan does not include all of the required elements.
4. 4a.	Is the UR Plan in compliance with each of the following: Contains a description of the types of records that are kept by the URC?			**NOTE:** Review IP, MHP UR Plan, URC minutes, URC records, and URC reports. • Are all the types of records described by the UR Plan kept by the URC? • Do the records contain all the required elements?
4b.	Contains a description of the types and frequency of the URC reports and the arrangements for distribution to individuals?			**NOTE:** Are the URC reports of the types and frequency specified in the UR plan? • Is there evidence of arrangements for distribution to individuals?
4c.	Provides for the beneficiary's confidentiality in all records and reports?			**NOTE:** Review records to ensure compliance with confidentiality requirements.

CRITERIA		IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
• *CFR, title 42, sections 456.212-213 and 456.232* • *CCR, title 9, chapter 11, section 1820.210*				**OUT OF COMPLIANCE:** • NFP. • Incomplete records. • Reports not distributed. • Lack of confidentiality protections. • Medical care criteria does not assess need for continued stay.
5.	Does the URC include anyone who is directly responsible for the care of the beneficiary whose care is being viewed?			**NOTE:** Review UR records, URC minutes, and medical records. • Identify care providers on URC and who is responsible for the care of the beneficiary.
• *CFR, title 42, section 456.206* • *CCR, title 9, chapter 11, section 1820.210*				**OUT OF COMPLIANCE:** • Care providers of beneficiary are present when URC reviews care provided to the beneficiary. • No backup replacement to URC to maintain required composition.
6. 6a.	Regarding the authorization process: If no Point of Authorization (POA) is involved in the authorization process, has the URC or its designee approved or denied the initial MHP payment authorization no later than the third working day from the day of admission?			**NOTE:** Use "Admission Summary Worksheet" and "Continued Stay Worksheet." • Review UR records, URC minutes, UR reports, medical records, records, and denials.

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
6b.	If the MHP uses a POA process, has the POA approved or denied the payment authorization request within 14 calendar days of receipt of the request?			
•	*CCR, title 9, chapter 11, sections 1820.220(h) and 1820.230(b)*	**OUT OF COMPLIANCE:** **6a. (URC) OUT OF COMPLIANCE:** URC or designee approved or denied the initial MHP payment authorization later than the third working day from the day of admission. **6b. (POA) OUT OF COMPLIANCE:** POA did not approve or deny the payment authorization within 14 calendar days of receipt of the request.		
7.	If a hospital's URC authorizes payment, at the time of the initial MHP authorization for payment, did the hospital's URC or its designee specify the date for the subsequent MHP payment authorization determination?			**NOTE:** Use "Admission Summary Worksheet" and "Continued Stay Worksheet." • Review UR records, URC minutes, UR reports, medical records, and denials.
•	*CCR, title 9, chapter 11, section 1820.230(c)*	**OUT OF COMPLIANCE:** • URC or designee did not specify the date for the subsequent MHP payment authorization determination.		

SECTION M— UTILIZATION REVIEW-SD/MC HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
8. 8a.	Did the URC or its designee, or POA authorize payment for administrative day services only when both of the following criteria (8a. & 8b.) have been met: During the hospital stay, the beneficiary previously met medical necessity criteria for acute psychiatric inpatient hospital services?			**NOTE:** Use "Admission Summary Worksheet" and "Continued Stay Worksheet." • Review UR records, POA records, URC minutes, UR reports, medical records, denials, and list of all non-acute placement facilities utilized by the facility.
8b.	There is no appropriate, non-acute treatment facility available and the facility has documented its minimum number of appropriate contacts: 1) The status of the placement option? 2) Date of the contact? 3) Signature of the person making the contact?			**NOTE:** If less than five contacts were made per week, look for written justification. • The MHP can waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.
• *CCR, title 9, chapter 11, sections 1820.230(d)(2)(A and,(B) and 1820.220(j)(5)(A and,(B)*		**OUT OF COMPLIANCE:** • URC or designee authorized payment for administrative day services for a beneficiary that had not previously met medical necessity criteria as required. • There is no appropriate, non-acute treatment facility available and the facility has not documented its minimum number of appropriate contacts.		

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
9.	Are persons employed or under contract to provide mental health services as physicians**,** psychologists, social workers, marriage and family therapists or professional clinical counselors (pending Centers for Medicare and Medicaid Services (CMS) approval) licensed, waivered, or registered with their licensing boards?			**NOTE:** Review licenses, waivers, and registrations.
•	*W&IC, section 5751.2*	**OUT OF COMPLIANCE:** • MHP employs or contracts with non-licensed/waivered/registered personnel to provide mental health services as physicians, psychologists, social workers, or marriage and family therapists.		
10. 10a.	Regarding Medical Care Evaluations (MCEs) or equivalent studies, does the UR plan contain the following: A description of the methods that the URC uses to select and conduct MCE or equivalent studies?			**NOTE:** 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?
10b.	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?			**NOTE:** 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.
10c.	Documentation that the MCE or equivalent studies have been analyzed?			

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
10d.	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?			
• *CFR, title 42, section 456.241 and 456.242* • *CCR, title 9, chapter 11, section 1820.210*		**OUT OF COMPLIANCE:** • NFP. • Plan does not contain description of URC methods. • URC not using methods. • Lack of documentation as required that MCE or equivalent findings are analyzed and how used for improved changes and to correct deficiencies or problems.		
11. 11a.	Regarding MCE or equivalent studies: Do the contents of the MCE or equivalent studies meet federal requirements?			**NOTE:** Review current and past MCE or equivalent studies for two years.
11b.	Has at least one MCE or equivalent study been completed each calendar year?			
11c.	Is a MCE or equivalent study in progress at all times?			
• *CFR, title 42, sections 456.242, 456.243, 456.244 and 456.245* • *CCR, title 9, chapter 11, section 1820.210*		**OUT OF COMPLIANCE:** • MCE or equivalent studies do not meet federal regulations.		

SECTION M— UTILIZATION REVIEW-SD/MC HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
Documentation: List documents reviewed that demonstrate compliance and provides specific explanation of reason(s) for in compliance or out of compliance.				
12.	Does the SD/MC hospital have 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?			
• *CCR, title 9, chapter 11, section 1810.440(c)*		**<u>OUT OF COMPLIANCE</u>:** • Documentation and medical record system does not meet the requirements of the contract and any applicable requirements of State, federal law and regulation.		

SECTION N— THERAPEUTIC BEHAVIORAL SERVICES

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
MUST MEET BOTH A & B BELOW				
RE: CERTIFIED CLASS				
				NOTE: If documentation of class certification is not in the chart ask the MHP to provide it. **NOTE**: The child/youth is receiving other specialty mental health services in addition to TBS.
				NOTE: A child/youth meets the requirements of "being considered for" placement in an RCL 12 or above placement when an RCL 12 or above placement is one option (not necessarily the only option) that is being considered as part of a set of possible solutions to address the child/youth needs. Additionally, whether or not an RCL 12 or above placement is available, a child/youth meets the requirements when his or her behavior could result in placement in such a facility if the facility were actually available.
1d.	Child/youth previously received TBS while a member of the certified class?			**NOTE:** Review prior TBS notification or other documentation.
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SECTION N— THERAPEUTIC BEHAVIORAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
2.	Does the plan for TBS document the following (2a-e):			
2a.	Specific target behaviors or symptoms that are jeopardizing the current place of residence or presenting a barrier to transitions (e.g. temper tantrums, property destruction, and assaultive behavior in school)?			
2b.	Specific interventions to resolve behaviors or symptoms, such as anger management techniques?			
2c.	Specific outcome measures that can be used to demonstrate that the frequency of targeted behaviors has declined and has been replaced by adaptive behaviors?			
2d.	A transition plan from the inception of TBS to decrease or discontinue TBS when these services are no longer needed or when the need to continue TBS appears to have reached a plateau in benefit effectiveness?			**NOTE:** Review the plan for TBS for evidence in the initial treatment plan of a timeline for reviewing the partial or complete attainment of behavioral benchmarks.
2e.	The manner for assisting parents/caregivers with skills and strategies to provide continuity of care when the service is discontinued?			**NOTE:** Review the plan for TBS for evidence in the initial treatment plan that describes how parents/caregivers will be assisted with skills and strategies to provide continuity of care when the service is discontinued or a timeline for developing how parents/caregivers will be assisted. • When the beneficiary receiving TBS is not a minor (age 18 - 20), the transition plan would involve parents/caregivers or other significant support persons in the beneficiary's life only with appropriate consent from the beneficiary.
• *DMH Information Notice No. 08-38* • *DMH Information Notice No. 09-10, Enclosure 1* • *DMH Information Notice No. 10-20, Enclosures 1 & 2*		**OUT OF COMPLIANCE:** • No plan for TBS. • Plan for TBS does not contain the components 2a-e.		