State of California—Health and Human Services Agency
Department of Health Care Services

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DATE: May 31, 2019

MHSUDS INFORMATION NOTICE NO.: 19-026

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS
CALIFORNIA STATE ASSOCIATION OF COUNTIES
CALIFORNIA CONSORTIUM OF ADDICTION PROGRAMS AND PROFESSIONALS

SUBJECT: AUTHORIZATION OF SPECIALTY MENTAL HEALTH SERVICES

PURPOSE

The purpose of this Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice (IN) is to communicate to county Mental Health Plans (MHPs) federal requirements related to the authorization of specialty mental health services (SMHS). This IN includes policy changes the Department of Health Care Services (DHCS) has made to ensure compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule).

Pursuant to Welfare and Institutions Code (W&I) section 14197.1(b), DHCS has the authority to implement these requirements via issuance of this IN in lieu of adopting regulations. To the extent that these requirements conflict with the California Code of Regulations (CCR), Title 9, Chapter 11, federal regulations and state law reflected in the requirements in this IN supersede those state regulations. DHCS will formally promulgate the regulations by July 1, 2022, as required by statute.

BACKGROUND

Pursuant to existing state and federal requirements, MHPs are required to operate a utilization management (UM) program that ensures beneficiaries have appropriate

access to SMHS.[1] The UM program must evaluate medical necessity, appropriateness, and efficiency of services provided to Medi-Cal beneficiaries prospectively, such as through prior or concurrent authorization procedures, or retrospectively, such as through retrospective authorization procedures.[2] Compensation to individuals that conduct UM activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a beneficiary.[3] MHPs must also establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to beneficiaries.[4] This program must include mechanisms to detect both underutilization and overutilization.[5] Additionally, MHPs must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, including maintenance of a comprehensive compliance program.[6]

MHPs are responsible for certifying that claims for all covered SMHS meet federal and state requirements, including medical necessity.[7] Pursuant to California's Medicaid State Plan, SMHS are provided, to Medi-Cal beneficiaries, based on medical necessity criteria, in accordance with an individualized client plan, approved, and authorized according to state requirements.[8] As specified in MHSUDS IN 17-040, certain services and service activities (e.g., assessment, plan development, and crisis intervention) are reimbursable prior to the client plan being approved while others (e.g., mental health services other than assessment and plan development, and non-emergency medication support) require an approved client plan.[9]

MHPs may place appropriate limits on a service based on medical necessity, or for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration, or scope to reasonably achieve their purpose and that services for beneficiaries with ongoing or chronic conditions are authorized in a manner that reflects the beneficiary's ongoing need for such services and supports.[10] Further, MHPs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.[11]

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[1] CCR, tit. 9, § 1810.440(b)
[2] MHP Contract, Ex. A, Att. 6.1 B.
[3] 42 CFR, § 438.210(e)
[4] 42 CFR, § 438.330(a)(1)
[5] 42 CFR, § 438.330(b)(3)
[6] 42 CFR, § 438.608(a)(1)
[7] MHP Contract, Ex. B, Sec. 5.B
[8] State Plan, section 3, Supplement 3 to Attachment 3.1-A, page 2c
[9] MHSUDS IN No., 17-040
[10] 42 CFR, § 438.210 (a)(4)(ii)
[11] 42 CFR, § 438.210 (a)(3)(ii)

Managed Care Final Rule

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule[12] (Final Rule), aimed at aligning the Medicaid managed care regulations with requirements for other major sources of coverage. The Final Rule revised the regulations for Medicaid Managed Care in Part 438 of the Code of Federal Regulations (CFR). MHPs are classified as Prepaid Inpatient Health Plans (PIHPs), and therefore, must comply with applicable federal managed care requirements. The Final Rule stipulates requirements for coverage and authorization that became effective July 1, 2017.[13]

Parity Final Rule

On March 30, 2016, CMS issued the Parity Rule in the Federal Register[14] (81. Fed. Reg. 18390) to strengthen access to mental health (MH) and substance use disorder (SUD) services for Medicaid beneficiaries. It aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program. The Parity Rule requires states to ensure that limitations imposed for Medicaid MH and SUD services are no more restrictive than the predominant limitations imposed for substantially all medical and surgical services within a benefit classification.[15] In addition, the Parity Rule prohibits an MHP from applying a non-quantitative treatment limitation (a requirement that limits the scope or duration of a benefit) to a mental health benefit unless the limitation is comparable to, and applied no more stringently, than it is applied to corresponding medical benefits.[16]

On October 13, 2017, Senate Bill 171, which codified the Parity Rule requirements in the Welfare and Institutions Code, became law. The statute requires DHCS to ensure that all covered mental health benefits and substance use disorder benefits, as those terms are defined in section 438.900 of Title 42 of the CFR, are provided in compliance with Parts 438, 440, 456, and 457 of Title 42 of the CFR, as amended March 30, 2016, as published in the Federal Register (81 Fed. Reg. 18390), and any subsequent amendment to those regulations, and any associated federal policy guidance issued by CMS.[17]

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[12] 81 CFR, §27497
[13] 42 CFR, § 438.210
[14] Medicaid Mental Health Parity Final Rule Federal Register: https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf
[15] 42 CFR, § 438.910(b)(1)
[16] 42 CFR, § 438.910(d)(1)
[17] W&I, § 14197.1(a)

Parity Assessment and Compliance Plan

The Parity Rule required DHCS to conduct an analysis of its delivery systems to determine if any applicable limitations exist.[18] This included a review of quantitative treatment limitations, financial and information requirements, and non-quantitative treatment limitations (NQTL). An NQTL is a limit on the scope or duration of benefits, which is not expressed numerically, such as prior authorization requirements. An NQTL may not be applied to MH/SUD benefits in a classification unless, under the policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the classification.[19]

DHCS submitted its Parity Compliance Plan to CMS to demonstrate compliance with the Parity Rule by the implementation deadline of October 2, 2017. The Parity Compliance Plan outlines the findings from DHCS' parity assessment. During its assessment of the State's authorization policies across delivery systems, DHCS identified inconsistencies in the application of standards and policies for authorization of both inpatient and outpatient services by MHPs and Medi-Cal Managed Care Plans (MCPs). Pursuant to DHCS' Parity Compliance Plan and federal Parity Rule requirements, this IN address these inconsistencies by implementing policy changes to align the policies governing the MHPs with those governing the MCPs.

POLICY

Requirements Applicable to Authorization of all SMHS

Effective immediately, MHPs must, in accordance with this IN, establish and implement written policies and procedures addressing the authorization of SMHS.[20] In general, authorization procedures and utilization management criteria must adhere to the following principles:

- Be based on SMHS medical necessity criteria and consistent with current clinical practice guidelines, principles, and processes;
- Be developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their scope of practice;
- Be evaluated, and updated if necessary, at least annually; and,
- Be disclosed to the MHP's beneficiaries and network providers.

[18] 42 CFR, § 438.920(b)(1)
[19] 42 CFR, § 438.920(d)(1)
[20] 42 CFR, § 438.210(b)(1)

MHPs shall ensure that all medically necessary covered SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.[21] MHPs shall not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the beneficiary [22]

MHPs shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs.[23] No individual, other than a licensed physician or a licensed mental health professional who is competent to evaluate the specific clinical issues involved in the SMHS requested by a beneficiary or a provider, may deny, or modify a request for authorization of SMHS for a beneficiary for reasons related to medical necessity.[24] MHPs shall notify the requesting provider in writing and give the beneficiary written notice of any decision by the MHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.[25] The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.[26]

MHPs shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate.[27]

MHPs must also comply with the following communication requirements:

- Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
- Maintain telephone access 24-hours a day, 7-days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of an outpatient service requiring prior authorization;

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[21] 42 CFR, § 438.210(a)(3)(i)
[22] 42 CFR, §§ 438.210(a)(3)(ii) and 438.210(a)(4)(i); see also CCR., tit. 9, §§ 1820.205; 1830.205; and 1830.210
[23] 42 CFR, § 438.210(b)(3)
[24] Health & Safety Code (HSC), § 1367.01(e)
[25] 42 CFR, § 438.210(c)
[26] 42 CFR, §§ 438.210(c), 438.404; MHP Contract, Ex. A, Att 12; see also MHSUDS IN No., 18-010E
[27] 42 CFR, § 438.210(b)(2)(i-ii)

- A physician shall be available for consultation and for resolving disputed requests for authorizations;[28]
- Disclose to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting them online;
- Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS;[29] and,
- Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

All of the MHP's authorization procedures shall comply with the Parity Rule, in accordance with requirements set forth in Title 42 of the CFR, part 438.910.

Concurrent Review for Psychiatric Inpatient Hospital, Psychiatric Health Facility Services

Effective immediately, MHPs are required to conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services. MHPs shall conduct concurrent review of treatment authorizations following the first day of admission. MHPs may elect to initially authorize multiple days, but each day of treatment must meet medical necessity and/or continued stay criteria.

For Medi-Cal reimbursement of psychiatric inpatient hospital services, the beneficiary must meet medical necessity criteria set forth in Title 9 of the CCR, section 1820.205. The beneficiary must meet the following medical necessity criteria for admission to a hospital for psychiatric inpatient hospital services:[30]

- Have an included diagnosis;
- 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; and,
- Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to one of the following:

[28] HSC, § 1371.4(a)
[29] 42 CFR, § 438.10(g)(2)(iv).
[30] CCR, tit. 9, § 1820.205(a)

1. Has symptoms or behaviors due to a mental disorder that (one of the following):
    - Represent a current danger to self or others, or significant property destruction.
    - Prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter.
    - Present a severe risk to the beneficiary's physical health.
    - Represent a recent, significant deterioration in ability to function.
2. Require admission for one of the following:
    - Further psychiatric evaluation.
    - Medication treatment.
    - Other treatment that can be reasonably provided only if the beneficiary is hospitalized.

The medical necessity criteria are applicable regardless of the legal status (voluntary or involuntary) of the beneficiary.

Continued stay services in a hospital shall be reimbursed when a beneficiary experiences one of the following:[31]

- Continued presence of indications that meet the medical necessity criteria;
- Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization;
- Presence of new indications that meet medical necessity criteria; and,
- Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in the hospital.

MHPs maintain responsibility to ensure that services furnished to beneficiaries are medically necessary and must ensure compliance with all requirements necessary for Medi-Cal reimbursement.[32] As such, the MHP must review documentation sufficient to determine that medical necessity criteria are met for acute days and administrative day criteria are met for administrative days claimed for reimbursement of Federal Financial Participation.

Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's' treating providers, including both the hospital and treating physician, in writing, within 24

[31] CCR, tit. 9, § 1820.205(b)
[32] W&I, § 14705(a)(3)

hours of the decision.[33] If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination. In the case of concurrent review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.[34] In cases where the MHP determines it will terminate, modify, or reduce services, the MHP must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

Emergency Admission Requirements

MHPs may not require prior authorization for an emergency admission for psychiatric inpatient hospital services or to a psychiatric health facility, whether the admission is voluntary or involuntary,[35] and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter, or clothing.[36] Upon notification by a hospital, MHPs shall authorize payment for out-of-network services when a beneficiary of the MHP, with an emergency psychiatric condition, is admitted to a hospital, or PHF, to receive psychiatric inpatient hospital services or PHF services.[37] After the date of admission, hospitals must request authorization for continued stay services for the beneficiary subject to concurrent review by the MHP in accordance with this IN.

Authorizing Administrative Days

A hospital may claim for administrative day services when a beneficiary no longer meets medical necessity criteria for acute psychiatric hospital services but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area.[38] In order to conduct concurrent review and authorization for administrative day service claims, the MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has

[33] HSC, § 1367.01(h)(3)
[34] HSC, § 1367.01(h)(3)
[35] CCR, tit. 9, § 1820.225(a); CCR, tit. 9, §§ 1820.205
[36] CCR, tit. 9, §§ 1820.205 and 1820.225
[37] CCR, tit. 9, §§ 1830.220, 1810.216, 1820.225, and 1830.245
[38] CCR, tit. 9, § 1820.230(d)(2)

not been made until and unless all five required contacts are completed and documented. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.

MHPs may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary.[39] The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact.[40]

Examples of appropriate placement status options include, but may not be limited to, the following:

- The beneficiary's information packet is under review;
- An interview with the beneficiary has been scheduled for [date];
- No bed available at the non-acute treatment facility;
- The beneficiary has been put on a wait list;
- The beneficiary has been accepted and will be discharged to a facility on [date of discharge];
- The patient has been rejected from a facility due to [reason]; and/or,
- A conservator deems the facility to be inappropriate for placement.

Concurrent Review of Crisis Residential Treatment Services and Adult Residential Treatment Services

MHPs must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). MHPs may not require prior authorization. If the MHP refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the MHP specifies the parameters (e.g., number of days authorized) of the authorization. The MHP must then reauthorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services.

In the absence of an MHP referral, MHPs shall conduct concurrent review of treatment authorizations following the first day of admission to a facility through discharge. MHPs

[39] CCR, tit. 9, § 1820.230(d)(2)(B)(1)
[40] CCR, tit. 9, § 1820.230(d)(2)(B)(2)

may elect to authorize multiple days, based on the beneficiary's mental health condition, for as long as the services are medically necessary.

As with authorization of psychiatric inpatient and PHF services, decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating provider within 24 hours of the decision[41] and care shall not be discontinued until the beneficiary's treating provider has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.[42] If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination. In cases where the MHP determines that care should be terminated (no longer authorized) or reduced, the MHP must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

Prior Authorization or MHP Referral for Outpatient SMHS

Effective immediately, MHPs must establish and implement policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS as specified below:

MHPs may not require prior authorization for the following services/service activities:

- Crisis Intervention;
- Crisis Stabilization;
- Mental Health Services;
- Targeted Case Management;
- Intensive Care Coordination; and,
- Medication Support Services.

MHPs may impose appropriate utilization controls by requiring all Assessments to be conducted by the MHP's clinical staff. In these cases, the MHPs are permitted to then make a referral to a network provider for treatment. However, if the MHP delegates, to the MHP's network providers, responsibility for conducting Assessments, prior authorization is not permissible. In addition, Mental Health Services – Rehabilitation, Targeted Case Management, and Intensive Care Coordination must be included on the beneficiary's Client Plan prior to service delivery.[43] Although the MHP may not require prior authorization for these services, the MHP retains the option to review and approve beneficiaries' Client Plans prior to service delivery.

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[41] HSC, § 1367.01(h)(3)
[42] HSC, § 1367.01(h)(3)
[43] MHSUDS IN No. 17-040

Prior authorization or MHP referral is required for the following services:

- Intensive Home-Based Services
- Day Treatment Intensive
- Day Rehabilitation
- Therapeutic Behavioral Services
- Therapeutic Foster Care

For purposes of prior authorization, referral by the MHP is considered to serve the same function as approving a request for authorization submitted by a provider or beneficiary.

DHCS considered the following factors in determining which services will be subject to MHP referral or prior authorization requirements:

- Service type;
- Appropriate service usage, cost, and effectiveness of service and service alternatives;
- Contraindications to service and service alternatives;
- Potential fraud, waste, and abuse;
- Patient and medical safety; and,
- Other clinically relevant factors.

MHPs may require providers to request payment authorization for the continuation of services at intervals specified by the MHP (e.g., every six months). MHPs shall determine these intervals based on the criteria and guidelines detailed in this IN.

Outpatient Authorization Timeframe and Documentation Requirements
MHPs must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination. For cases in which a provider indicates, or the MHP determines, that the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires, but no later than 72 hours after receipt of the request for service.[44] The MHP may extend the timeframe for making an authorization decision for up to 14 additional calendar days, if the following conditions are met:

[44] 42 CFR, § 438.210(d)(2)

1. The beneficiary, or the provider, requests an extension; or,
2. The MHP justifies (to the State upon request), and documents, a need for additional information and how the extension is in the beneficiary's interest.[45]

The MHP referral or prior authorization shall specify the amount, scope, and duration of treatment that the MHP has authorized. MHPs must document their determinations of whether a service requires MHP referral or prior authorization and maintain that documentation in accordance with Title 42 of the CFR, part 438.3(h).

If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination. In cases where the MHP terminates, reduces, or suspends a previously authorized service, the MHP must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services. The beneficiary's notice shall meet the requirements to notify beneficiaries of an adverse benefit determination.[46]

Retrospective Authorization Requirements
MHPs must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). MHPs may conduct retrospective authorization of SMHS under the following limited circumstances:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or,
- Beneficiary's failure to identify payer (e.g., for inpatient psychiatric hospital services).

In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements.[47]

UTILIZATION REVIEW

Functions related to utilization review and auditing of documentation standards are distinct from utilization management and authorization functions. Nothing in this IN

[45] 42 CFR, § 438.210(d)(1)
[46] 42 CFR, §§ 438.210(c), 438.404; MHP Contract, Ex. A, Att 12; see also MHSUDS IN No., 18-010E
[47] HSC, § 1367.01(a)

prohibits the MHPs from conducting utilization review and/or auditing activities in accordance with state and federal requirements. MHPs retain the right to monitor compliance with any contractual agreements between an MHP and the MHP's network providers and may disallow claims and/or recoup funds, as appropriate, in accordance with the MHP's obligations to DHCS. For example, the MHP may disallow claims and recoup funds if it determines a service, while authorized, was not furnished to the beneficiary.

ONGOING MONITORING REQUIREMENTS

MHPs are responsible for demonstrating ongoing compliance with the Parity Rule and this IN. MHPs are required to maintain policies and procedures and to provide additional evidence of compliance with requirements upon request by DHCS and during compliance reviews and/or External Quality Review Organization reviews of each MHP. If, at any time, DHCS determines the MHP to be out of compliance with requirements outlined in this IN, the MHP will be required to submit a Plan of Correction, as well as evidence of correction, to the Department.

MHPs must submit written policies and procedures, addressing the requirements of this Information Notice, to DHCS via email to MHSDFinalRule@dhcs.ca.gov by August 1, 2019.

If you have questions regarding this IN, please contact the Mental Health Services Division at MHSDFinalRule@dhcs.ca.gov.

Sincerely,

Original signed by

Brenda Grealish, Acting Deputy Director
Mental Health & Substance Use Disorder Services