

**DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS**

TECHNICAL ASSISTANCE GUIDE

**BEHAVIORAL HEALTH REQUIREMENTS
ROUTINE MEDICAL SURVEY
OF
PLAN NAME**

DATE OF SURVEY:

PLAN COPY

Issuance of this June 1, 2022 Technical Assistance Guide renders all other versions obsolete.

FULL SERVICE/BEHAVIORAL HEALTH TAG

BEHAVIORAL HEALTH REQUIREMENTS

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Requirement BH-001: Utilization Review (UR) Policies and Procedures

INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Behavioral Health Medical Director
- Clinical Director
- Utilization Management (UM) Director
- Grievance Officer

DOCUMENTS TO BE REVIEWED

- Policies and procedures describing the Plan's utilization review process for MH/SUD treatment service requests
- Policies and procedures describing the Plan's utilization review process for MH/SUD post-stabilization care requests
- Policies and procedures describing the Plan's review of appeals involving a denial of MH/SUD treatment requests
- Policies, procedures, and other internal guidance describing the Plan's process for making medical necessity determinations, including decisions concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health and substance use disorders
- Policies, procedures, and other internal guidance describing the Plan's use of UM criteria in determining whether MH/SUD treatment requests are medically necessary

BH-001 - Key Element 1:

1. The Plan's UR Policies and Procedures related to SB 855 were reviewed and approved by the Department.

Section 1352; Section 1367.01(b).

Assessment Question	
1.1	Has the Plan filed with the Department all of its current utilization review policies and procedures related to SB 855 via Exhibit(s) J-9? Section 1352; Section 1367.01(b)

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BH-001 - Key Element 2:

- 2. The Plan maintains policies and procedures describing utilization review of MH/SUD treatment requests and its process for making medical necessity determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health (MH) and substance use disorders (SUD).**

Section 1367.01(b); Section 1374.721(b) and (c), and (f)(3); Section 1374.72(a)(3) and (7).

Assessment Questions	
2.1	Do the Plan's policies and/or procedures describe Plan activities and measures to ensure MH/SUD treatment addresses the specific needs of each individual enrollee? Section 1367.01(b); Section 1374.72(a)(3)(A)
2.2	Do the Plan's policies and/or procedures describe Plan activities and measures to ensure MH/SUD treatment is clinically appropriate in terms of type, frequency, extent, site, and duration? Section 1374.72(a)(3)(A)(ii)
2.3	Do the Plan's policies and/or procedures describe Plan activities and measures for making medical necessity determinations concerning service intensity for enrollees diagnosed with a MH/SUD? Section 1374.721(f)(3)(B); Section 1374.72(a)(7)
2.4	Do the Plan's policies and/or procedures describe Plan activities and measures for making medical necessity determinations concerning level of care placement for enrollees diagnosed with a MH/SUD? Sections 1374.721(b) and (c)
2.5	Do the Plan's policies and/or procedures describe Plan activities and measures for making medical necessity determinations concerning continued stay for enrollees diagnosed with a MH/SUD? Sections 1374.721(b) and (c); Section 1374.72(a)(7)
2.6	Do the Plan's policies and/or procedures describe Plan activities and measures for making medical necessity determinations concerning transfer or discharge for enrollees diagnosed with a MH/SUD? Sections 1374.721(b) and (c); Section 1374.72(a)(7)

BH-001 - Key Element 2:

- 3. The Plan maintains policies and procedures ensuring use of compliant criteria when making any medical necessity determination.**

Section 1374.721(a)-(c), and (f)(3)-(4).

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Assessment Questions	
3.1	Do the Plan's policies and/or procedures require application of criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of mental health and substance use disorder treatment service requests ? Section 1374.721(a)-(c) and (f)(3)-(4).
3.1.1	Do the Plan's policies and/or procedures require application of non-profit criteria when conducting utilization review of MH/SUD treatment service requests from enrollees or their designated representatives? Section 1374.721(a)-(c) and (f)(3)-(4)
3.2	Do the Plan's policies and/or procedures require application of criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of requests for post-stabilization care of mental health and substance use disorders? Section 1374.721(a)-(c)
3.3	Do the Plan's policies and/or procedures require application of criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of appealed denials or modifications of mental health and substance use disorder services? Section 1374.721(a)-(c) and (f)(3)-(4)
3.4	Do the Plan's policies and/or procedures permit use of criteria that are not identified in APL 21-002 or approved by the Department only if such criteria are for MH/SUD services that are (1) outside the scope of the applicable non-profit association criteria OR (2) related to advancements in technology or types of care that are not covered in the most recent versions of the non-profit association criteria? Section 1374.721(c)(1) and (2)

End of Requirement BH-001: UR Program Policies and Procedures

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Requirement BH-002: Utilization Review Criteria

INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Behavioral Health Medical Director
- Clinical Director (if applicable)
- UM Director

DOCUMENTS TO BE REVIEWED

- UR or claims processing policies and/or procedures that identify MH/SUD services that require medical necessity review
- Contracts or agreements with nonprofit professional associations for MH/SUD criteria and training
- EOCs, Subscriber contracts, enrollees' contracts if includes list of MH/SUD services that require medical necessity review
- Criteria or guidelines used for utilization review of MH/SUD services
- MH/SUD training materials
- Evidence of UM staff attendance at required training
- Policies and procedures that describe processes for reviewing and selecting clinical criteria and guidelines and staff responsible for review and selection
- Minutes of committees responsible for review and selection of clinical criteria and guidelines
- Reports, memoranda, or recommendations regarding selection of clinical criteria for utilization review of MH/SUD services
- Log of requests for criteria used for utilization review of MH/SUD services

BH-002 - Key Element 1:

- 1. The Plan adopted, for utilization review of MH/SUD benefits, criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty?**
Section 1363(b)(5); Section 1374.721(b), (c)(1)-(2), (d), and (e)(3).

Assessment Questions	
1.1	Does the Plan maintain a list of all MH/SUD services that are prospectively, retrospectively, or concurrently reviewed, based in whole or in part on medical necessity, for approval, modification, delay, or denial, including the array of services available at each service intensity level? Section 1363.5(b)(5); Section 1374.721(a) and (e)(3)
1.2	Does the Plan maintain a list of nonprofit criteria the Plan uses for each of the MH/SUD services that require prospective, retrospective, or concurrent review? Section 1363.5(b)(5); Section 1374.721(b) and (e)(3)

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1.3	Did the Plan identify any criteria or guidelines that are not on the initial list of approved nonprofit criteria set forth in Attachment A to APL 21-002? Section 1374.721(c)(1) and (2), (e)(3)
1.3.1	If yes, did the Plan confirm in writing that the Plan filed for review and approval by the Department all criteria or guidelines that are not on the initial list of approved nonprofit criteria? Section 1374.721(d)

BH-002 - Key Element 2:

- 2. The Plan evaluates criteria used for utilization review of MH/SUD services at least annually to ensure they are based on current generally accepted standards of mental health and substance use disorder care.**
Section 1363.5(b)(2)-(3); Section 1374.721(a), (d) and (f)(1).

Assessment Questions	
2.1	Did the Plan demonstrate it reviews at least annually, and updates, if necessary, all criteria used in conducting utilization review of MH/SUD services to ensure they are based on current generally accepted standards of MH/SUD care? Section 1363.5(b)(2)-(3); Section 1374.721(a) and (f)(1)
2.2	If the Plan conducts utilization review of MH/SUD services that are (1) outside the scope of the applicable non-profit association criteria; OR (2) related to advancements in technology or types of care that are not covered in the most recent versions of the non-profit association criteria, did the Plan's annual review of MH/SUD criteria include research to determine whether applicable nonprofit criteria have become available? Section 1374.721(a)-(c) and (f)(1)

BH-002 - Key Element 3:

- 3. The Plan conducts a formal education program by a nonprofit clinical association when the Plan adopts that association's criteria.**
Section 1374.721(e)(1) and (e)(2).

Assessment Questions	
3.1	Does the Plan maintain policies and/or procedures describing how the Plan implements a formal education program about the Plan's MH/SUD clinical review criteria, by each nonprofit clinical specialty association selected to provide utilization review criteria, to educate all Plan staff and contracted third parties that review claims, conduct utilization reviews, or make medical necessity determinations? Section 1374.721(e)(1)
3.2	Did the Plan demonstrate that all staff who review claims, conduct utilization review, and/or make medical necessity determinations regarding MH/SUD

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BH-002 - Key Element 4:

4. The Plan provides MH/SUD clinical review criteria and training materials to providers and enrollees at no cost.

Section 1363.5(b)(4); Section 1374.721(e)(3).

Assessment Questions	
4.1	Does the Plan maintain policies and/or procedures describing how the Plan provides MH/SUD clinical review criteria and any training material or resources to providers and enrollees at no cost? Section 1363.5(b)(4); Section 1374.721(e)(3)
4.2	Did the Plan demonstrate that it provided, at no cost, MH/SUD clinical review criteria or training materials when a request was received? Section 1363.5(b)(4); Section 1374.721(e)(3)

End of Requirement BH-002: Utilization Review Criteria

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Requirement BH-003: Medical Necessity Decision-Making

INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Behavioral Health Medical Director
- Clinical Director (if applicable)
- UM Director
- UR Staff (UM & Grievance Staff)
- Grievance Officer

DOCUMENTS TO BE REVIEWED

- MH/SUD Medical Necessity Denial and Modification Files
- MH/SUD Appeal Files

BH-003 - Key Element 1:

1. The Plan conducts utilization review of requests for MH/SUD treatment services using criteria consistent with, and bases medical necessity determinations on, generally accepted standards of mental health and substance use disorder care.

Section 1367.01(h)(1)-(5); Section 1374.721(a)-(d) and (e)(7); Section 1374.72(a)(1)-(7).

Assessment Questions	
1.1	Do the Plan's files demonstrate the health care professional who made the medical necessity determination passed IRR testing? Section 1374.721(e)(7)
1.2	Do the Plan's files demonstrate the Plan uses criteria approved by the Department when reviewing MH/SUD treatment requests? Section 1374.721(a)-(d)
1.2.1	If the Plan used non-profit criteria, did the Plan apply the appropriate criteria from the relevant clinical specialty? Section 1374.721(b)
1.2.2	If the Plan did not use non-profit criteria, was the exception permitted under Section 1374.721(c)(1) or (2)? Section 1374.721(c)
1.3	Do the Plan's files demonstrate the health care professional who made the medical necessity determination considered the specific needs of the enrollee, whether clinically appropriate in type, frequency, extent, site, and duration? Section 1374.72(a)(3)(A)

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1.4	Do the Plan's files demonstrate the Plan made timely medical necessity decisions? Section 1367.01(h)(1) and (2)
1.5	Do the Plan's files demonstrate the Plan's written communications include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decision regarding medical necessity? Section 1367.01(h)(4)
1.6	Do the Plan's files demonstrate the Plan's written communications include information about how the enrollee may file a grievance with the Plan? Section 1367.01(h)(4); Section 1374.72(a)(7)

BH-003 - Key Element 2:

2. The Plan conducts utilization review of appeals involving modifications and denials of MH/SUD treatment requests using criteria consistent with, and bases medical necessity determinations on, generally accepted standards of mental health and substance use disorder care.

Section 1368(a)(5); Section 1374.721(a)-(c) and (e)(7); Section 1374.72(a)(1)-(7); Rule 1300.68(d)(3)-(4).

Assessment Questions	
2.1	Do the Plan's files demonstrate the health care professional who made the appeal determination based on medical necessity passed IRR testing? Section 1374.721(e)(7)
2.2	Do the Plan's files demonstrate the Plan uses criteria approved by the Department when reviewing appeals of MH/SUD treatment request modifications and denials? Section 1374.721(a)-(c)
2.2.1	If the Plan used non-profit criteria, did the Plan apply the appropriate criteria from the relevant clinical specialty? Section 1374.721(b)
2.2.2	If the Plan did not use non-profit criteria, was an exception permitted under Section 1374.721(c)(1) or (2)? Section 1374.721(c)
2.3	Do the Plan's files demonstrate the health care professional who made the appeal determination based on medical necessity for the appeal considered the specific needs of the enrollee, whether clinically appropriate in type, frequency, extent, site, and duration? Section 1374.72(a)(3)(A)

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2.4	Do the Plan's files demonstrate the Plan's written response to the appeal includes a clear and concise explanation of the Plan's decision, the criteria, clinical guidelines, or medical policies used in reaching the determination, and clinical reasons for the medical necessity decision? Rule 1300.68(d)(3)-(4)
2.6	Do the Plan's files demonstrate the Plan's written response includes an application for independent medical review and instructions for further information, and an envelope addressed to the Department? Rule 1300.68(d)(4); Section 1374.72(a)(7)

End of Requirement BH-003: Medical Necessity Decision-Making

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Requirement BH-004: Quality Assurance

INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Behavioral Health Medical Director
- Clinical Director (if applicable)
- UM Director
- Grievance Officer
- Quality Assurance Director

DOCUMENTS TO BE REVIEWED

- P Quality Assurance Program Description
- Utilization Management Program Description
- List of all staff who conduct MH/SUD utilization review
- Policies and procedures describing the Plan's MH/SUD interrater reliability testing process
- Copy of the Plan's MH/SUD interrater reliability test
- Interrater Reliability testing results for the survey review period for all staff who conduct utilization review
- Policies, procedures, and other internal guidance describing the Plan's process for providing remediation for poor interrater reliability
- Evidence of remediation for staff who failed to pass interrater reliability testing
- Policies, procedures, and other internal guidance describing the Plan's process for running interrater reliability reports
- Policies, procedures, and other internal guidance describing the Plan's process for monitoring how MH/SUD criteria are used to conduct utilization review
- Policies and procedures describing the Plan's process for detecting and correcting over- and under-utilization of MH/SUD services
- Policies and procedures describing the Plan's process for identifying emergent trends in appeals

BH-004 - Key Element 1:

- 1. The Plan conducts interrater reliability testing to ensure consistency in medical necessity decision-making covering all aspects of MH/SUD utilization review.**

Section 1374.721(e)(5) and (7) and (f)(3)(A); Rule 1300.70(a)(1) and (c).

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Assessment Questions	
1.1	Do the Plan's policies and/or procedures describe Plan activities and measures to ensure the Plan conducts interrater reliability testing to ensure consistency in MH/SUD utilization review? Section 1374.721(e)(5)
1.1.1	Do the Plan's policies and/or procedures describe Plan activities and measures to ensure the Plan conducts interrater reliability testing for all individuals who conduct MH/SUD utilization review on behalf of the Plan? Section 1374.721(e)(5)
1.1.2	Do the Plan's policies and/or procedures describe Plan activities and measures to ensure the Plan requires a pass rate of at least 90%? Section 1374.721(e)(7)
1.1.3	Do the Plan's policies and/or procedures describe Plan activities and measures to ensure the Plan conducts immediate remediation of poor interrater reliability results? Section 1374.721(e)(7)
1.1.4	Do the Plan's policies and procedures describe Plan activities and measures to ensure the Plan provides interrater reliability testing for all new staff before they can conduct utilization review without supervision? Section 1374.721(e)(7)
1.2	Did the Plan demonstrate all staff who conduct utilization review completed interrater reliability testing? Section 1374.721(e)(5)
1.2.1	Did the Plan demonstrate that all staff who conduct utilization review met the Plan's required threshold for passing interrater reliability testing? Section 1374.721(e)(7)
1.2.2	If any staff failed to pass the Plan's interrater reliability test, did the Plan demonstrate it provided immediate remediation? Section 1374.721(e)(7)
1.2.3	If the Plan provided remediation, did the Plan demonstrate its corrective action was effective to ensure consistency in utilization review? Rule 1300.70(a)(1) and (c)
1.2.4	If the Plan hired new staff during the survey review period, did the Plan demonstrate they performed utilization review under supervision until they completed interrater reliability testing? Section 1374.721(e)(7)
1.3	Did the Plan demonstrate it conducts interrater reliability testing covering all aspects of utilization review? Section 1374.721(e)(5)
1.3.1	Did the Plan's testing cover prospectively, retrospectively, or concurrently reviewing of MH/SUD treatment requests for medical necessity? Section 1374.721(e)(5) and (f)(3)(A)

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1.3.2	Did the Plan's testing cover approving, modifying, delaying, or denying MH/SUD treatment requests based on medical necessity? Section 1374.721(e)(5) and (f)(3)(A)
1.3.3	Did the Plan's testing cover evaluating appropriateness, level of care, service intensity, efficacy, and efficiency of MH/SUD services, benefits, procedures, and settings to determine whether the service or benefit is covered as medically necessary for an enrollee? Section 1374.721(e)(5) and (f)(3)(B)

BH-004 - Key Element 2:

2. The Plan runs interrater reliability reports to evaluate how clinical guidelines are used.

Section 1374.721(e)(6).

Assessment Questions	
2.1	Do the Plan's policies and/or procedures describe Plan activities and measures to ensure the Plan runs interrater reliability reports about how utilization review criteria are used? Section 1374.721(e)(6)
2.2	Did the Plan demonstrate it runs interrater reliability reports about how utilization review criteria are used? Section 1374.721(e)(6)

BH-004 - Key Element 3:

3. The Plan established and implemented a process to evaluate its compliance with MH/SUD utilization review requirements.

Section 1367.01(e), (h), (j); Section 1374.721(e)(4); Rule 1300.68(b)(1) and (d)(2); Rule 1300.70(a)(1) and (3), (b)(1)(A)-(B), (b)(1)(B), (b)(3), (b)(2)(H)(2) and (c).

Assessment Questions	
3.1	Do the Plan's policies and/or procedures describe Plan activities and measures to ensure the Plan tracks, identifies, and analyzes how clinical review criteria are used to certify care, deny care, and support the appeals process? Section 1374.721(e)(4)
3.2	Did the Plan demonstrate it tracks, identifies, and analyzes how clinical review criteria are used to certify care, deny care, and support the appeals process? Section 1374.721(e)(4)
3.3	Did the Plan demonstrate it performs ongoing monitoring and evaluation of the utilization of mental health and substance use disorder services to ensure that a level of care which meets professionally recognized standards of practice is being delivered to all enrollees? Section 1367.01(j); Rule 1300.70(a)(3); Rule 1300.70(b)(1)(A)

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3.4	If the Plan has capitation or risk-sharing contracts for delivery of MH/SUD care, did the Plan demonstrate it maintains a mechanism to detect and correct under-service by an at-risk MH/SUD provider, including possible under-utilization of specialist services and preventative MH/SUD care services? Rule 1300.70(b)(2)(H)(2)
3.5	Did the Plan demonstrate it maintains a process for evaluating complaints related to mental health and substance use disorder care? Section 1367.01(j)
3.5.1	Did the Plan demonstrate it assesses for trends among grievances related to mental health and substance use disorder care? Section 1367.01(j); Rule 1300.68(b)(1)
3.5.2	Did the Plan demonstrate it implemented actions to correct identified problems, including mechanisms to communicate actions and results to appropriate Plan employees and/or contracted providers? Section 1367.01(j); Rule 1300.68(d)(2); Rule 1300.70(a)(1), (b)(1)(A)-(B) and (c)
3.5.3	Did the Plan demonstrate that it evaluated the effectiveness of corrective actions and implemented further actions as needed? Section 1367.01(j); Rule 1300.70(a)(1) and (c)

End of Requirement BH-004: Quality Assurance

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Requirement BH-005: Access & Availability

INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Behavioral Health Medical Director
- Clinical Director (if applicable)
- Director of Contracting/Provider Relations
- Quality Assurance Director

DOCUMENTS TO BE REVIEWED

- Quality Assurance Program Description
- UM Program Description
- Standards of Accessibility Program Description (submitted to Department as Exhibit I-5)
- Provider Manual
- Policies and procedures describing the Plan's process for approving and arranging out of network MH/SUD services
- Evidence demonstrating both the approval of and the making of arrangements for OON MH/SUD services, and evidence the Plan ensures delivery of these services to enrollees
- Policies, procedures, and other internal guidance describing the Plan's process for monitoring its MH/SUD network
- Evidence of MH/SUD network monitoring
- Evidence of corrective action when MH/SUD network adequacy issues are identified
- Evidence of follow-up on corrective action to ensure effectiveness
- UM files

BH-005 - Key Element 1:

1. The Plan arranges coverage for out-of-network treatment when medically necessary MH/SUD services are not available in-network with applicable geographic and timely access standards.

Section 1374.72(d).

Assessment Questions	
1.1	Do the Plan's policies and/or procedures describe Plan activities and measures for arranging out-of-network (OON) coverage if medically necessary treatment of a mental health or substance use disorder is not available in network within geographic and timely access standards? Section 1374.72(d)

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| 1.2 | Do the Plan's records demonstrate the Plan arranged for an OON provider when services were not available in network within geographic and timely access standards?
Section 1374.72(d) |
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BH-005 - Key Element 2:

2. The Plan monitors its provider networks and takes effective corrective action to ensure covered MH/SUD services are accessible and available.

Rule 1300.51(d)(l)(5); Rule 1300.67.2(f); Rule 1300.67.2.2(d)(2)(A) and (d)(3); Rule 1300.70(a)(1) and (3).

Assessment Questions	
2.1	Does the Plan document the monitoring of its network(s) of MH/SUD providers and facilities to ensure access to all levels of medically necessary services (including inpatient, partial hospitalization, IOP etc.) in accordance with the standards, policies and procedures approved by the Department? Rule 1300.51(d)(l)(5); Rule 1300.67.2(f); Rule 1300.67.2.2(d)(2)(A)
2.2	Does the Plan implement and follow-up on corrective action when monitoring activities identify network inadequacies related to MH/SUD providers? Rule 1300.67.2.2(d)(3); Rule 1300.70(a)(1) and (3)

End of Requirement BH-005: Access & Availability

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Requirement BH-006: Delegation Oversight

INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Behavioral Health Medical Director
- Clinical Director (if applicable)
- UM Director
- Delegation Oversight Staff

DOCUMENTS TO BE REVIEWED

- Delegation Contracts and/or Administrative Service Agreements (ASAs)
- Policies and/or Procedures describing the Plan's oversight and monitoring activities of delegated MH/SUD utilization review activities
- Delegate audit tools and results
- Delegate MH/SUD UM reports
- Meeting minutes of relevant Plan committees responsible for overseeing MH/SUD Delegates
- Corrective actions imposed on MH/SUD Delegates

BH-006 - Key Element 1:

- 1. The Plan filed all contracts delegating utilization review of mental health and/or substance use disorder services to another entity with the Department.**
Rule 1300.51(d)(N)(1).

Assessment Question	
1.1	Has the Plan filed with the Department all of its current plan-to-plan contracts and ASAs related to delegation of MH/SUD utilization review? Rule 1300.51(d)(N)(1)

BH-006 - Key Element 2:

- 1. The Plan maintains quality assurance processes to ensure entities delegated to perform utilization review of mental health and/or substance use disorder services comply with its UM Program.**
Section 1367.01(a), (b), and (j); Section 1374.721(a)-(c), (e), and (h); Section 1374.72(a)(3)(A); Rule 1300.51(d)(N)(2).

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Assessment Questions	
2.1	Does the Plan maintain policies and procedures describing its processes for monitoring utilization review of MH/SUD services conducted by its delegated entities? Section 1367.01(a) and (j); Section 1374.721(a), (e), and (h); Section 1374.72(a)(3)(A); Rule 1300.51(d)(N)(2)
2.1.1	Do the Plan's policies and/or procedures describe how the Plan ensures its delegate(s) uses only those criteria from nonprofit associations listed in APL 21-002 Attachment A and alternate criteria approved by the Department when making medical necessity determinations for requested MH/SUD services? Section 1367.01(j); Section 1374.721(a)-(c) and (h); Section 1374.72(a)(3)(A); Rule 1300.51(d)(N)(2)
2.1.2	Do the Plan's policies and/or procedures describe how the Plan ensures all staff who review claims, conduct utilization reviews, and/or make medical necessity decisions on behalf its delegate(s) participate in a formal education program about the Plan's clinical review criteria? Section 1374.721(e)(1) and (h); Rule 1300.51(d)(N)(2)
2.1.3	Do the Plan's policies and/or procedures describe how the Plan tracks, identifies, and analyzes how its delegates use clinical review criteria to certify care, deny care, and support the appeals process? Section 1374.721(e)(4) and (h); Rule 1300.51(d)(N)(2)
2.1.4	Do the Plan's policies and/or procedures describe how the Plan ensures its delegates conduct IRR testing for all staff who conduct utilization review of MH/SUD treatment requests? Section 1374.721(e)(5) and (h); Rule 1300.51(d)(N)(2)
2.1.5	Do the Plan's policies and/or procedures describe how the Plan ensures its delegates achieve IRR pass rates of at least 90 percent for any staff who conduct utilization review of MH/SUD treatment requests? Section 1374.721(e)(7) and (h); Rule 1300.51(d)(N)(2)
2.1.6	Do the Plan's policies and/or procedures describe how the Plan ensures its delegates implement remediation for poor interrater reliability results? Section 1374.721(e)(7) and (h); Rule 1300.51(d)(N)(2)

BH-006 - Key Element 3:

1. The Plan performs continuous monitoring of its delegates, takes effective corrective action where deficiencies are identified, and conducts follow-up to assess the effectiveness of its remedial measures where indicated.

Section 1367.01(a) and (j); Section 1370; Section 1374.721(h); Rule 1300.51(d)(N)(2); Rule 1300.70(a)(1).

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Assessment Questions	
3.1	Did the Plan demonstrate it conducts oversight of each of its delegated entities consistent with the standards, methodology, and frequency established in its policies and/or procedures? Section 1367.01(j); Section 1374.721(h); Rule 1300.51(d)(N)(2)
3.2	Based on review of files from the Plan's delegate(s), does the Plan perform adequate oversight of its delegates to ensure compliance with applicable MH/SUD utilization review requirements? Section 1367.01(a) and (j); Section 1374.721(h); Rule 1300.70(a)(1)
3.3	Does the Plan initiate corrective action when its oversight activities find the delegates out of compliance with applicable MH/SUD utilization review requirements? Rule 1300.70(a)(1) and (b)(1)(B)
3.4	Does the Plan perform follow-up to ensure corrective actions were effective in resolving the identified compliance issues? Rule 1300.70(a)(1) and (b)(1)(B)

End of Requirement BH-006: Delegation Oversight

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Statutory/Regulatory Citations

CA Health and Safety Code section 1352

(a) A licensed plan shall, within 30 days after any change in the information contained in its application, other than financial or statistical information, file an amendment thereto in the manner the director may by rule prescribe setting forth the changed information. However, the addition of any association, partnership, or corporation in a controlling, controlled, or affiliated status relative to the plan shall necessitate filing, within a 30-day period of an authorization for disclosure to the director of financial records of the person pursuant to Section 7473 of the Government Code.

(b) Prior to a material modification of its plan or operations, a plan shall give notice thereof to the director, who shall, within 20 business days or such additional time as the plan may specify, by order approve, disapprove, suspend, or postpone the effectiveness of the change, subject to Section 1354.

(c) A plan shall, within five days, give written notice to the director in the form as by rule may be prescribed, of a change in the officers, directors, partners, controlling shareholders, principal creditors, or persons occupying similar positions or performing similar functions, of the plan and of a management company of the plan, and of a parent company of the plan or management company. The director may by rule define the positions, duties, and relationships which are referred to in this subdivision.

(d) The fee for filing a notice of material modification pursuant to subdivision (b) shall be the actual cost to the director of processing the notice, including overhead, but shall not exceed seven hundred fifty dollars (\$750).

CA Health and Safety Code section 1363.5(b)(2)-(5)

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

...

(2) Be consistent with sound clinical principles and processes.

(3) Be evaluated, and updated if necessary, at least annually.

(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

(5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

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CA Health and Safety Code section 1367.01(a), (b), (e), (h) and (j)

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

...

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

...

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the 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 current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

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(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

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(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

...

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

CA Health and Safety Code section 1368(a)(5)

(a) Every plan shall do all of the following:

...

(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one

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of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

CA Health and Safety Code section 1370

Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in plan or provider quality of care or utilization reviews by peer review committees which are composed chiefly of physicians and surgeons or dentists, psychologists, or optometrists, or any of the above, for any act performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of a plan or to any person or entity designated by the plan to review activities of the plan or provider committees shall not alter the status of the records or of the proceedings as privileged communications.

The above prohibition relating to discovery or testimony shall not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the director in conducting surveys pursuant to Section 1380.

This section shall not be construed to confer immunity from liability on any health care service plan. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a health care service plan, the cause of action shall exist notwithstanding the provisions of this section.

CA Health and Safety Code section 1374.72(a)(1)-(7), and (d)

(a)(1) Every health care service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) For purposes of this section, "mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and

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Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(3)(A) For purposes of this section, "medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

(B) This paragraph does not limit in any way the independent medical review rights of an enrollee or subscriber under this chapter.

(4) For purposes of this section, "health care provider" means any of the following:

(A) A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.

(C) A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.

(D) An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.

(E) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.

(F) A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.

(G) A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.

(H) A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

(5) For purposes of this section, "generally accepted standards of mental health and substance use disorder care" has the same meaning as defined in paragraph (1) of subdivision (f) of Section 1374.721.

(6) A health care service plan shall not limit benefits or coverage for mental health and substance use disorders to short-term or acute treatment.

(7) All medical necessity determinations by the health care service plan concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of Section 1374.721. This paragraph

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does not deprive an enrollee of the other protections of this chapter, including, but not limited to, grievances, appeals, independent medical review, discharge, transfer, and continuity of care.

...

(d) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary followup services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to “arrange coverage to ensure the delivery of medically necessary out-of-network services” includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

CA Health and Safety Code section 1374.721(a)-(e), (f)(3) and (h)

(a) A health care service plan that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the plan, and any entity acting on the plan’s behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a health care service plan shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health care service plan from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).

(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

(d) If a health care service plan purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the plan shall verify and document before use that the criteria were developed in accordance with subdivision (a).

(e) To ensure the proper use of the criteria described in subdivision (b), every health

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care service plan shall do all of the following:

- (1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health care service plan's staff, including any third parties contracted with the health care service plan to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.
 - (2) Make the education program available to other stakeholders, including the health care service plan's participating providers and covered lives. Participating providers shall not be required to participate in the education program.
 - (3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and health care service plan enrollees.
 - (4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.
 - (5) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).
 - (6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.
 - (7) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.
- (f) The following definitions apply for purposes of this section:

...

(3) "Utilization review" means either of the following:

- (A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to enrollees.
- (B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.

...

(h) This section applies to a health care service plan that conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on behalf of a health care service plan.

28 CCR 1300.51(d)(I)(5); (d)(N)(1)-(2)

(d) Exhibits to Plan Application.

(I) Description of Health Care Arrangements.

NOTE: Providers of Health Care Services. The information in this item is for the purpose of assessing the adequacy of the applicant's health care provider arrangements.

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If the service area of the plan and the distribution of its enrollees is so geographically limited that all plan health care providers are readily available and accessible to all enrollees, no geographic division of the provider information required in this part need be made.

However, if applicant's service area is divided into separate provider networks for regions within the service area, the information required in this Item-1 must be furnished separately for each such region and provider network.

...

(5) Applicant's Standards of Accessibility. Attach as Exhibit I-5 a detailed description of the applicant's standards with respect to the accessibility and its procedures for monitoring the accessibility of services. Standards should be expressed in terms of the level of accessibility which the applicant has as its objective and the minimum level of accessibility below which corrective action will be taken. Cover each of the following:

- (a) the availability of appointments for primary care and specialty services,
- (b) the availability of after hours and emergency services,
- (c) an assessment of probable patient waiting times for scheduled appointments,
- (d) the proximity of specialists, hospitals, etc. to sources of primary care, and
- (e) a description of applicant's system for monitoring and evaluating accessibility. Discuss applicant's system for monitoring problems that develop, including telephone inaccessibility, delayed appointment dates, waiting time for appointments, other barriers to accessibility, and any problems or dissatisfaction identified through complaints from contracting providers or grievances from subscribers or enrollees.)

...

(N) Contracts for Administrative Services.

(1) As Exhibit N-1, attach a copy of each contract which applicant has for administrative or management services, or consulting contracts, or which applicant intends to have for the Health Plan.

(2) As Exhibit N-2, describe applicant's administrative arrangements to monitor the proper performance of such contracts and the provisions which are included in them to protect applicant, its plan business and its enrollees and providers in the event there is a failure of performance or the contract is terminated.

28 CCR 1300.67.2(f)

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;

28 CCR 1300.67.2.2(c)(5)(G); (d)(2)(A), and (d)(3)

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

...

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(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:

(A) Tracking and documenting network capacity and availability with respect to the standards set forth in subsection (c);

...

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all contracted providers affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

28 CCR 1300.68(b)(1) and (d)(3)-(4)

(b) The plan's grievance system shall include the following:

(1) An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

...

(d) The plan shall respond to grievances as follows:

...

(2) The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance. (3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

(3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and

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instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

28 CCR 1300.70(a)(1), (3), (b)(1)(A)-(B)

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

...

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

...

(b) Quality Assurance Program Structure and Requirements.

(1) Program Structure.

To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

(A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;

(B) quality of care problems are identified and corrected for all provider entities;

...

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(A) There must be a written QA plan describing the goals and objectives of the program and organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.

...

(c) In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the to the Department.