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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

June 28, 2019

Sent via e-mail to: Matthew.White@hsd.cccounty.us

Matthew P. White, MD, Director
Contra Costa County Behavioral Health Services
1220 Morello Ave Ste. 101
Martinez, CA 94553

SUBJECT: Annual County Performance Unit Report

Dear Director White:

The Department of Health Care Services (DHCS) is responsible for monitoring compliance to requirements of the Substance Abuse Block Grant (SABG) and operated by Contra Costa County.

The County Performance Unit (CPU) within the Substance Use Disorder Program, Policy, and Fiscal Division (SUDPPFD) of DHCS conducted a review of the County's compliance with contract requirements based on responses to the monitoring instrument, discussion with county staff, and supporting documentation provided by the County.

Enclosed are the results of Contra Costa County's 2018-19 SABG compliance review. The report identifies deficiencies, required corrective actions, advisory recommendations, and referrals for technical assistance.

Contra Costa County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 7/29/2019. Please follow the enclosed instructions when completing the CAP. Supporting CAP documentation may be e-mailed to the CPU analyst or mailed to the address listed below.

If you have any questions regarding this report or need assistance, please contact me.

Sincerely,

BL Counter

Becky Counter
(916) 713-8567
becky.counter@dhcs.ca.gov

Distribution:

To: Director White

CC: Tracie Walker, Performance & Integrity Branch Chief
Sandi Snelgrove, Prevention and Family Services Section Chief.
Janet Rudnick, Utilization Review Section Chief
Cynthia Hudgins, Quality Monitoring Section Chief
Susan Jones, County Performance Supervisor
Tianna Hammock, Drug Medi-Cal Monitoring Unit I Supervisor
Stephanie Quok, Drug Medi-Cal Monitoring Unit II Supervisor
Tiffiny Stover, Postservice Postpayment Unit I Supervisor
Eric Painter, Postservice Postpayment Unit II Supervisor
Jessica Fielding, Office of Women, Perinatal and Youth Services Supervisor
Patricia Gulfam, Prevention Quality Assurance and Support Unit Supervisor
Fatima Matal Sol, Contra Costa County, Program Chief AOD Services

Lead CPU Analyst: Becky Counter **Assisting CPU Analyst(s):** Jessica Jenkins	**Date of Review:** 5/14/2019 - 5/15/2019
County: Contra Costa County	**County Address:** 1220 Morello Ave., Ste. 101 Martinez, CA 94553
County Contact Name/Title: Fatima Matal Sol AOD Program Chief	**County Phone Number/Email:** (925) 335-3307 Fatima.matalsol@hsd.cccounty.us
Report Prepared by: Becky Counter	**Report Approved by:** Susan Jones

REVIEW SCOPE

I. Regulations:
   a. 45 CFR; Part 96; Subpart L; §96.121 through 96.137: Substance Abuse Prevention and Treatment Block Grant
   b. 42 USC, Section 300x-21 through 300x-66: Substance Abuse Prevention and Treatment Block
   c. HSC, Division 10.5, Section 11750 – 11970: State Department of Health Care

II. Program Requirements:
   a. State Fiscal Year (SFY) 2018-19 State County Contract, herein referred to as State County Contract
   b. State of California *Youth Treatment Guidelines Revised August 2002*
   c. DHCS *Perinatal Services Network Guidelines SFY 2016-17*
   d. National Culturally and Linguistically Appropriate Services (CLAS)
   e. Mental Health and Substance Use Disorders Services (MHSUDS) Information Notices

ENTRANCE AND EXIT CONFERENCE SUMMARIES

Entrance Conference:
An entrance conference was conducted at 1220 Morello Ave., Martinez, CA on 5/14/2019. The following individuals were present:

- Representing DHCS:
  Becky Counter, AGPA
  Jessica Jenkins, AGPA

- Representing Contra Costa County:
  Fatima Matal Sol, AOD Program Chief
  Mark Messerer, Program Manager
  Christopher Pedraza, Program Manager
  Michelle Richardson, Program Manager
  Trisha Seastrom, Program Manager
  Chet Spikes, Asst. IT Director
  Alicia Pormenter, HS Accountant
  Jorge Pena, BH IT Consultant

During the Entrance Conference the following topics were discussed:

- Introductions
- DHCS provided an overview of the review
- County provided an overview of the County and the services available

Exit Conference:
An exit conference was conducted at 1220 Morello Ave., Martinez, CA on 5/15/2019. The following individuals were present:

- Representing DHCS:
  Becky Counter, AGPA
  Jessica Jenkins, AGPA

- Representing Contra Costa County:
  Matt White, MD, Medical Director
  Trisha Seastrom, Program Manager
  Christopher Pedraza, Program Manager
  Mark Messerer, Program Manager
  Michelle Richardson, Program Manager
  Fatima MatalSol, AOD Program Chief

During the Exit Conference the following topics were discussed:

- Reviewed all follow-up items for both the County and DHCS.
- DHCS outlined the next steps and when the County should expect their final report.

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	0
2.0 SABG Monitoring	0
3.0 Perinatal	0
4.0 Adolescent/Youth Treatment	0
5.0 Primary Prevention	0
6.0 Cultural Competence	0
7.0 CalOMS and DATAR	2
8.0 Privacy and Information Security	0

PREVIOUS CAPs

During the SFY 2018-19 review, the following CAPs with CDs were discussed and are still outstanding.

2014-15:

CD # 13: Open Admissions
Finding: Counties are required to submit CalOMS Tx discharge data for individuals no longer in treatment, or submit annual updates for individuals who remain in treatment for over a year. According to the CalOMS Tx Open Admissions Report, the County is not submitting CalOMS Tx discharge data or annual updates as required.
Reason for non-clearance of CD: December 2015 - May 15, 2019 Contra Costa continues to send error reports to providers requesting their attention to enter updates into the system for the Open Admissions report. Contra Costa County recently switched from Insyst to a new system (ShareCare), the transition has temporarily forced redirection of resources to address the immediate needs. The county has also successfully hired two individuals whose sole responsibility will be to manage the quality of SUD data to include CalOMS, DMC claims and DATAR. The county states they are confident that the data quality/management team will ensure the integrity of the system data.
County plan to remediate: Contra Costa County now has ShareCare to track collection and billing and are in a data reconciliation process at this time.
Original expected date of completion: December 2015
Updated/revised date of completion: July 2019

CD # 14: Open Providers
Finding: It is a contract requirement that counties submit CalOMS Tx data or a *Provider No Activity (PNA)* record to DHCS to maintain compliance with the SAPT BG and State-County Contract. According to the CalOMS Tx Open Provider Report, Contra Costa County is not reporting into CalOMS and did not submit a Provider No Activity report (PNA) as required.
Reason for non-clearance of CD: December 2015 – May 15, 2019 several issues were found within the MPF that caused the continued errors in the Provider No Activity report. These errors are being addressed with the DHCS MPF file team to resolve all outstanding issues. As of now, the system has started to collect information; however, the reporting process is flawed and inaccurate. While these issues are being corrected as quickly as possible, it has hindered the timelines of completing other duties. Contra Costa recently switched from Insyst to a new system (ShareCare), the transition has temporarily forced redirection of resources to address the immediate needs. Fortunately, ShareCare is now stable and with the addition of new staff in AOD who will be dedicated to address the remaining deficiencies, we are confident that we will be moving towards maintenance.
County plan to remediate: Contra Costa County has switched from Insyst to a new system ShareCare.
Original expected date of completion: December 2015
Updated/revised date of completion: July 2019

2016-17:

CD 10.57.b: **Open Providers**
County's response: Please see response above.
Reason for non-clearance of CD:
County plan to remediate:
Original expected date of completion:
Updated/revised date of completion:

CD 10.57.d: Open Admissions
County's response: Please see response above.
Reason for non-clearance of CD:
County plan to remediate:
Original expected date of completion:
Updated/revised date of completion:

2017-18:

CD 7.41 a: Open Admissions
County's response: See response above
Reason for non-clearance of CD:
County plan to remediate:
Original expected date of completion:
Updated/revised date of completion:

CD 7.41 b: Open Admissions
County's response: See response above
Reason for non-clearance of CD:
County plan to remediate:
Original expected date of completion:
Updated/revised date of completion:

CORRECTIVE ACTION PLAN

Pursuant to the State County Contract, Exhibit A, Attachment I A1, Part I, Section 3, 7, (a-d) each compliance deficiency (CD) identified must be addressed via a Corrective Action Plan (CAP). The CAP is due within thirty (30) calendar days of the date of this monitoring report. Advisory recommendations are not required to be addressed in the CAP.

Please provide the following within the completed 2018-19 CAP.

a) A statement of the compliance deficiency (CD).
b) A list of action steps to be taken to correct the CD.
c) A date of completion for each CD.
d) Who will be responsible for correction and ongoing compliance.

The CPU analyst will monitor progress of the CAP completion.

7.0 CALIFORNIA OUTCOMES MEASUREMENT SYSTEM TREATMENT (CalOMS Tx) AND DRUG AND ALCOHOL TREATMENT ACCESS REPORT (DATAR)

The following deficiencies in CalOMS and DATAR regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 7.34.a:

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, B, 3, 5, 6

(3) Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.

(5) Contractor shall submit CalOMS-Tx admissions, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider No activity" report records in an electronic format approved by DHCS.

(6) Contractor shall comply with the CalOMsTx Data Compliance Standards established by DHCS identified in Document 3S for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, D, 6

Contractor shall comply with the treatment and prevention data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may result in withholding SABG funds.

Finding: The County's open provider report is not current.

CD 7.34.b:

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, B, 3, 5, 6

(3) Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.

(5) Contractor shall submit CalOMS-Tx admissions, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider No activity" report records in an electronic format approved by DHCS.

(6) Contractor shall comply with the CalOMsTx Data Compliance Standards established by DHCS identified in Document 3S for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, D, 6

Contractor shall comply with the treatment and prevention data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may result in withholding SABG funds.

Finding: The County's open admission report is not current.

9.0 TECHNICAL ASSISTANCE

Contra Costa County did not request Technical Assistance during this fiscal year.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

June 28, 2019

Sent via e-mail to: Matthew.White@hsd.cccounty.us

Matthew P. White, M.D., Director
Contra Costa County Behavioral Health Services
1220 Morello Ave. Suite 101
Martinez CA 94553

SUBJECT: Annual County Performance Unit Report

Dear Director White:

The Department of Health Care Services (DHCS) is responsible for monitoring compliance to the requirements of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver and the terms of the Intergovernmental Agreement operated by Contra Costa County.

The County Performance Unit (CPU) within the Substance Use Disorder Program, Policy, and Fiscal Division (SUDPPFD) of DHCS conducted a review of the County's compliance with contract requirements based on responses to the monitoring instrument, discussion with county staff, and supporting documentation provided by the County.

Enclosed are the results of Contra Costa County's 2018-19 DMC-ODS compliance review. The report identifies deficiencies, required corrective actions, new requirements, advisory recommendations, and referrals for technical assistance.

Contra Costa County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 7/29/2019. Please follow the enclosed instructions when completing the CAP. Supporting CAP documentation may be e-mailed to the CPU analyst or mailed to the address listed below.

If you have any questions regarding this report or need assistance, please contact me.

Sincerely,

Jessica Jenkins

Jessica Jenkins
(916) 713-8577
Jessica.jenkins@dhcs.ca.gov

Distribution:

To: Director White

CC: Don Braeger, Substance Use Disorders - Program, Policy and Fiscal Division Chief
Tracie Walker, Performance & Integrity Branch Chief
Sandi Snelgrove, Prevention and Family Services Section Chief.
Cynthia Hudgins, Quality Monitoring Section Chief
Janet Rudnick, Utilization Review Section Chief
Susan Jones, County Performance Unit Supervisor
Tianna Hammock, Drug Medi-Cal Monitoring Unit I Supervisor
Stephanie Quok, Drug Medi-Cal Monitoring Unit II Supervisor
Tiffiny Stover, Postservice Postpayment Unit I Supervisor
Eric Painter, Postservice Postpayment Unit II Supervisor
Jessica Fielding, Office of Women, Perinatal and Youth Services Unit Supervisor
Patricia Gulfam, Prevention Quality Assurance and Support Unit Supervisor
Fatima Matal Sol, Contra Costa County Substance Use Disorder Administrator

Lead CPU Analyst: Jessica Jenkins **Assisting CPU Analyst(s):** Becky Counter	**Date of Review:** 5/14/2019 - 5/15/2019 **Date of DMC-ODS Implementation:** 6/30/2017
County: Contra Costa	**County Address:** 1220 Morello Ave., Suite 101 Martinez, CA 94553
County Contact Name/Title: Fatima Matal Sol, Substance Use Disorder Administrator	**County Phone Number/Email:** (925) 335-3307 Fatima.Matasol@cchealth.org
Report Prepared by: Jessica Jenkins	**Report Approved by:** Susan Jones

REVIEW SCOPE

I. Regulations:
   a. Special Terms and Conditions (STCs) for California's Medi-Cal 2020 section 1115(a) Medicaid Demonstration STC, Part X: Drug Medi-Cal Organized Delivery System
   b. 42 CFR; Chapter IV, Subchapter C, Part 438; §438.1 through 438.930: Managed Care

II. Program Requirements:
   a. State Fiscal Year (SFY) 2018-19 Intergovernmental Agreement (IA)
   b. Mental Health and Substance Use Disorders Services (MHSUDS) Information Notices

ENTRANCE AND EXIT CONFERENCE SUMMARIES

Entrance Conference:
An entrance conference was conducted at 1220 Morello Ave. Suite 101, Martinez CA 94553 on 5/14/2019. The following individuals were present:

- Representing DHCS:
  Jessica Jenkins, Associate Governmental Program Analyst (AGPA)
  Becky Counter, AGPA

- Representing Contra Costa County:
  Fatima Mata Sol, AODS Chief
  Mark Messerer, Program Manager
  Christopher Pedraza, Program Manager
  Michelle Richardson, Program Manager
  Trisha Seastrom, Program Manager
  Chet Spikes, Assistant IT Director
  Alicia Pomento, Accountant
  Jorge Pena, BH IT Consultant

During the Entrance Conference the following topics were discussed:

- Introductions
- DHCS provided an overview of the review
- County provided an overview of the County and the services available

Exit Conference:
An exit conference was conducted at 1220 Morello Ave. Suite 101, Martinez CA 94553 on 5/15/2019. The following individuals were present:

- Representing DHCS:
  Jessica Jenkins, AGPA
  Becky Counter, AGPA

- Representing Contra Costa County:
  Matthew White, MD Director
  Fatima Mata Sol, AODS Chief
  Mark Messerer, Program Manager
  Christopher Pedraza, Program Manager
  Michelle Richardson, Program Manager
  Trisha Seastrom, Program Manager

During the Exit Conference the following topics were discussed:

- Reviewed all follow-up items for both the County and DHCS.
- DHCS outlined the next steps and when the County should expect their final report.

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	0
2.0 Member Services	0
3.0 Service Provisions	0
4.0 Access	1
5.0 Continuity and Coordination of Care	1
6.0 Grievance, Appeal, and Fair Hearing Process	0
7.0 Quality	3
8.0 Program Integrity	4

PREVIOUS CAPs

During the SFY 2018-19 review, the following CAP(s) with CD(s) were discussed and are still outstanding.

2017-18:

CD 7.50
Finding: The Plan does not adequately monitor their CalOMS Tx reports: Open Admissions Report and Open Providers Report.
Reason for non-clearance of CD: December 2015 - May 15, 2019

- Contra Costa County recently switched from Insyst to a new system (ShareCare). The system had started to collect information, however, the reporting process was flawed and inaccurate. While these issues were being corrected as quickly as possible, there were delays in the completion of other tasks.
- Several issues were found within the MPF that caused the continued errors in the Provider No Activity report. These errors are being addressed with the DHCS MPF file team to resolve all outstanding issues.

County plan to remediate: ShareCare is now stable and effective. The county has also successfully hired two individuals whose sole responsibility will be to manage the quality of SUD data to include CalOMS, DMC claims and DATAR. The county states they are confident that the data quality/management team will ensure the integrity of the system data.

Original expected date of completion: December 2015
Updated/revised date of completion: July 2019
Updated/revised date of completion: 3/31/2019
Updated/ revised date of completion: 10/1/19

CD 8.62:
Finding: The Plan's procedure for reporting any potential fraud, waste, or abuse did not include referring any potential fraud, waste, or abuse to the Department's Medicaid Fraud Control Unit.
Reason for non-clearance of CD: The County intended to revise a Mental Health policy to include SUD language as they merged Mental Health with SUD but they determined this was not a viable option due to both entities needing to agree on content which resulted in a delay in correcting the deficiency.
County plan to remediate: The County will use the Mental Health policy as a reference to create an AODS information notice specifically referencing network providers in the DMC-ODS.
Original expected date of completion: 2/28/2019
Updated/ revised date of completion: 10/1/2019

CD 8.63:
Finding: The Plan's written procedure did not include a provision regarding the prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to DHCS.

Reason for non-clearance of CD: The County intended to revise a Mental Health policy to include SUD language as they merged Mental Health with SUD but they determined this was not a viable option due to both entities needing to agree on content which resulted in a delay in correcting the deficiency.
County plan to remediate: The County will use the Mental Health policy as a reference to create an AODS information notice specifically referencing network providers under Drug Medi-Cal.

Original expected date of completion: 2/28/2019
Updated/ revised date of completion: 10/1/2019

CORRECTIVE ACTION PLAN

Pursuant to the Intergovernmental Agreement, Exhibit A, Attachment I, Part II, Section EE, 2 each compliance deficiency (CD) identified must be addressed via a Corrective Action Plan (CAP). The CAP is due within thirty (30) calendar days of the date of this monitoring report. Advisory recommendations are not required to be addressed in the CAP.

Please provide the following within the completed 2018-19 CAP:

a) A statement of the compliance deficiency (CD).
b) A list of action steps to be taken to correct the CD.
c) A date of completion for each CD.
d) Who will be responsible for correction and ongoing compliance.

The CPU analyst will monitor progress of the CAP completion.

4.0 ACCESS

The following deficiencies in access regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 4.27:

MHSUDS Information Notice: 18-019

Attestation

For all network providers who deliver covered services, each provider's application to contract with the Plan must include a signed and dated statement attesting to the following:

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
2. A history of loss of license or felony conviction;
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. The application's accuracy and completeness the beneficiary receives from community and social support providers.

Finding: The Plan did not provide evidence to support that they ensure providers submit attestations.

5.0 COORDINATION OF CARE

The following deficiencies in Coordination of Care for regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 5.33:

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 3, iii. a – f.

iii. The Contractor shall implement procedures to deliver care to and coordinate services for all of its beneficiaries. These procedures shall meet Department requirements and shall do the following:

a. Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity.
b. Coordinate the services the Contractor furnishes to the beneficiary:
    i. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.
    ii. With the services the beneficiary receives from any other managed care organization.
    iii. With the services the beneficiary receives in FFS Medicaid.
    iv. With the services the beneficiary receives from community and social support providers.
c. Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.
d. Share with the Department or other managed care organizations serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.
e Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.
f. Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

Finding: The Plan's procedures do not include the following:

- Make a best effort to conduct an initial screening within 90 days.

7.0 QUALITY

The following deficiencies in quality regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 7.40:

Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 2.

2. The Contractor shall have a written description of the QM Program, which clearly defines the QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement.

Finding: The Plan's written description of the Quality Management (QM) Program does not include the following requirement:

- Adopt or establishes quantitative measures to assess performance

CD 7.46:

Intergovernmental Agreement Exhibit A, Attachment I, III, LL, 4, i – ix.

4. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:
    i. Timeliness of first initial contact to face-to-face appointment.
    ii. Frequency of follow-up appointments in accordance with individualized treatment plans.
    iii. Timeliness of services of the first dose of NTP services.
    iv. Access to after-hours care.
    v. Responsiveness of the beneficiary access line.
    vi. Strategies to reduce avoidable hospitalizations.
    vii. Coordination of physical and mental health services with waiver services at the provider level.
    viii. Assessment of the beneficiaries' experiences.
    ix. Telephone access line and services in the prevalent non-English languages.

Finding: The Plan does not have a Quality Improvement (QI) Plan for FY 18/19.

CD 7.50:

Intergovernmental Agreement Exhibit A, Attachment I, III, FF, 3, i, c-f.

i. The CalOMS-Tx business rules and requirements are:
Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.
    a. Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements.

b. Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider no activity" report records in an electronic format approved by DHCS.
d. Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified in (Document 3S) for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

Intergovernmental Agreement Exhibit A, Attachment I, III, AA, 2, iv.

2. Each subcontract shall:
   iv. Ensure that the Contractor monitor the subcontractor's performance on an ongoing basis and subject it to an annual onsite review, consistent with statutes, regulations, and Article III.PP.

Finding: The following CalOMS Tx report(s) are non-compliant:

- Open Admissions Report
- Open Providers Report

8.0 PROGRAM INTEGRITY

The following program integrity deficiencies in regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 8.58:

Intergovernmental Agreement Exhibit A, Attachment I, III. PP, 4, i – ii.

i. The substance use disorder medical director's responsibilities shall at a minimum include all of the following:
   a. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
   b. Ensure that physicians do not delegate their duties to non-physician personnel.
   c. Develop and implement medical policies and standards for the provider.
   d. Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
   e. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
   f. Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, determine the medical necessity of treatment for beneficiaries
   g. Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

ii. The substance use disorder medical director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however, the substance use disorder medical director shall remain responsible for ensuring all delegated duties are properly performed..

Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 5, v.

v. Written roles and responsibilities and a code of conduct for the medical director shall be clearly documented, signed and dated by a provider representative and the physician.

Finding: The written roles and responsibilities, and code of conduct did not include the following requirement:

- Signed and dated by a provider representative

CD 8.61:

Intergovernmental Agreement Exhibit A, Attachment I, III. HH, 1-2.
All complaints received by Contractor regarding a DMC certified facility shall be forwarded to: Submit to Drug Medi-Cal Complaints:

Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Alternatively, call the Hotlines:

Drug Medi-Cal Complaints/Grievances: (800) 896-4042
Drug Medi-Cal Fraud: (800) 822-6222

Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities may be made by telephoning the appropriate licensing branch listed below:

SUD Compliance Division:
Public Number: (916) 322-2911
Toll Free Number: (877) 685-8333
The Complaint Form is available and can may be submitted online:
http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx

Counties shall be responsible for investigating complaints and providing the results of all investigations to DHCS's e-mail address by secure, encrypted e-mail to SUDCountyReports@dhcs.ca.gov within two (2) business days of completion.

Finding: The Plan does not forward complaints regarding DMC certified facilities to Drug Medi-Cal Complaints. AND the Plan does not forward complaints regarding Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities to SUD Compliance Division.

CD 8.62:

Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, i-ii, a.i-vii

i. The Contractor, and its subcontractors to the extent that the subcontractors are delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.
ii. The arrangements or procedures shall include the following:
    a. A compliance program that includes, at a minimum, all of the following elements:
        i. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.
        ii. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the Chief Executive Officer and the board of directors.
        iii. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Contract.
        iv. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and state standards and requirements under this Contract.

v. Effective lines of communication between the compliance officer and the organization's employees.
vi. Enforcement of standards through well-publicized disciplinary guidelines.
viii. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.

Finding: The Plan's submitted procedures for detecting and preventing fraud, waste, and abuse were from 2007 and do not include the following requirement(s):

- The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the Chief Executive Officer and the board of directors.
- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Contract.
- A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and state standards and requirements under this Contract.
- Effective lines of communication between the Compliance Officer and the organization's employees.
- Enforcement of standards through well-publicized disciplinary guidelines.
- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements

CD 8.63:

Intergovernmental Agreement Exhibit A, Attachment I, II ,H, 5, ii, g.

g. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the Department Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

Finding: The Plan's procedure for reporting any potential fraud, waste, or abuse did not include referring any potential fraud, waste, or abuse to the Department's Medicaid Fraud Control Unit.