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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

July 22, 2019

Sent via e-mail to: dutecht@co.fresno.ca.us

Dawan Utecht, Director
Fresno County Department of Behavioral Health
4441 East Kings Canyon Road
Fresno, CA 93702-3604

SUBJECT: Annual County Performance Unit Report

Dear Director Utecht:

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

The County Performance Unit (CPU) within the Substance Use Disorder Program, Policy, and Fiscal Division (SUD-PPFD) 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 Fresno County's 2018-19 SABG compliance review. The report identifies deficiencies, required corrective actions, advisory recommendations, and referrals for technical assistance.

Fresno County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 8/22/2019. 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,

Trang Huynh

Trang Huynh
(916) 713-8570
trang.huynh@dhcs.ca.gov

Substance Use Disorder
Program, Policy and Fiscal Division
County Performance Unit
P.O. Box 997413, MS 2627
Sacramento, CA 95814
http://www.dhcs.ca.gov

Distribution:

To: Director Utecht,

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 Unit Supervisor
Patricia Gulfam, Prevention Quality Assurance and Support Unit Supervisor
Katherine Anderson, Fresno County Principal Staff Analyst

Lead CPU Analyst: Trang Huynh **Assisting CPU Analyst(s):** Jessica Jenkins	**Date of Review:** 6/17/2019 - 6/18/2019
County: Fresno	**County Address:** 3133 N. Millbrook Avenue Fresno, CA 93703
County Contact Name/Title: Katherine Anderson, Principal Staff Analyst	**County Phone Number/Email:** 559-600-6060 kathyanderson@co.fresno.ca.us
Report Prepared by: Trang Huynh	**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 3133 N. Millbrook Ave, Fresno, CA on 6/17/2019. The following individuals were present:

- Representing DHCS:
  Trang Huynh, Associate Governmental Program Analyst (AGPA)
  Jessica Jenkins, AGPA

- Representing Fresno County:
  Susan Holt, Deputy Director
  Kannika Toonnachat, Division Manager
  Dawan Utecht, Director
  Katherine Anderson, Principal Staff Analyst
  Sharon Erwin, Senior Staff Analyst
  Chris Schreiber, Utilization Review Specialist
  Julie Apperson, Clinical Supervisor
  Lesby Flores, Division Manager
  Joseph Rangel, Division Manager
  Stacy VanBruggen, Division Manager
  Jeffery Robinson, Clinical Supervisor
  Cesar Rodriguez, Staff Analyst
  Aimie Rojas, Clinical Supervisor

During the Entrance Conference the following topics were discussed:

- Introductions
- Overview of the monitoring purpose and process
- County system of service overview
- Previous fiscal year CAP follow-up

Exit Conference:
An exit conference was conducted at 3133 N. Millbrook Ave, Fresno, CA on 6/18/2019. The following individuals were present:

- Representing DHCS:
  Trang Huynh, AGPA
  Jessica Jenkins, AGPA

- Representing Fresno County:
  Jolie Gordon Brower, Division Manager
  Joseph Rangel, Division Manager
  Lesby Flores, Division Manager
  Elizabeth Vasquez, Compliance Officer
  Cesar Rodriguez, Staff Analyst
  Katherine Anderson, Principal Staff Analyst
  Kannika Toonnachat, Division Manager
  Sharon Erwin, Senior Staff Analyst

During the Exit Conference the following topics were discussed:

- Review compliance deficiencies and recommendations.

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	1
2.0 SABG Monitoring	0
3.0 Perinatal	0
4.0 Adolescent/Youth Treatment	0
5.0 Primary Prevention	0
6.0 Cultural Competence	1
7.0 CalOMS and DATAR	2
8.0 Privacy and Information Security	1

PREVIOUS CAPs

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

2017-18:

CD 4.30:
Finding: The County does not provide referrals for AYT services not available within the County.
County reason for non-clearance of CD: DBH had been working with a provider in Los Angeles County to execute an agreement to provide adolescent residential services for Fresno County youth. Unfortunately, contract negotiations with that provider ceased in April 2019. The out-of-county provider determined that it would not be cost effective to enter into an agreement with Fresno County, given the number of Fresno County youth they would ultimately serve.
County plan to remediate: Fresno County has discussed the possibility of issuing a RFP for this modality in partnership with other neighboring counties who have faced the same challenges. Merced, Tulare and Kings Counties have expressed interest verbally. Fresno County staff are currently working on organizing a regional workgroup to begin more detailed discussions for this proposed regional effort.
Original expected date of completion: 10/2018
Updated/ revised date of completion: April 2020

CD 7.41.a:
Finding: The County's open provider report is not current.
County reason for non-clearance of CD: With the implementation of the DMC-ODS and a new IT system concurrently, Fresno County has encountered multiple technical difficulties. While we work through these issues with our new reporting and billing system, our providers are not able to fully comply with CalOMS requirements.
County plan to remediate: DBH IT is actively working through these issues now. Quality assurance reports have been developed in our IT system that will assist our providers in identifying errors with CalOMS data. DBH IT will be working with providers to correct errors and prepare CalOMS data for submission. Providers will be invited to meet individually with DBH IT to correct errors and complete CalOMs data submissions. DBH IT will provide ongoing support to providers as needed to ensure compliance.
Original expected date of completion: March 31, 2018
Updated/ revised date of completion: September 2019

CD 7.41.b:
Finding: The County's open admissions report is not current.
County reason for non-clearance of CD: With the implementation of the DMC-ODS and a new IT system concurrently, Fresno County has encountered multiple technical difficulties. While we work through these issues with our new reporting and billing system, our providers are not able to fully comply with CalOMS requirements.
County plan to remediate: DBH IT is actively working through these issues now. Quality assurance reports have been developed in our IT system that will assist our providers in identifying errors with our CalOMS data. DBH IT will be working with providers to correct errors and prepare CalOMS data for submission. DBH IT will provide ongoing support to providers as needed to ensure compliance.

Original expected date of completion: March 31, 2018
Updated/ revised date of completion: September 2019

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.

1.0 ADMINISTRATION

A review of the County's Organizational Chart, subcontracted contracts, and policies and procedures was conducted to ensure compliance with applicable regulations and standards. The following deficiency in regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCY:

CD 1.6:

SABG State-County Contract, Exhibit A, Attachment I AI, Part III, F
Contractor shall document the total number of referrals necessitated by religious objection to other alternative SUD providers. The Contractor shall annually submit this information to DHCS' Program Support and Grants Management Branch by e-mail at CharitableChoice@dhcs.ca.gov by October 1…

Finding: The County did not submit documentation of the total number of referrals necessitated by religious objection to DHCS Program Support and Grants Management Branch by October 1, 2018.

6.0 CULTURAL COMPETENCE

The following deficiency in Cultural Competence regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCY:

CD 6.31:

SABG State-County Contract, Exhibit A, Attachment I AI, Part II, O
Contractor shall regularly access (e.g. review population information available through Census, compare to information obtained in the California Outcome Measurement System for Treatment (CalOMS-Tx) to determine whether the population is being reached, survey Tribal representatives for insight in potential barriers) the substance use services needs of the American Indian/Alaskan Native(AI/AN) population within the County geographic area, and shall engage in regular and meaningful consultation and collaboration with elected officials of the tribe, Rancheria, or their designee for the purposes of identifying issues/barriers to service delivery and improvement of the quality, effectiveness and accessibility of services available to AI/NA communities within the County.

Finding: The County did not provide evidence of regular and meaningful consultation and collaboration with tribal representatives within the County.

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.

8.0 PRIVACY AND INFORMATION SECURITY

The following deficiency in Privacy and Information Security regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCY:

CD 8.37:

45 CFR Section 164.526

SABG State-County Contract, Exhibit F, F-1, 3, D, 10

Amendment of Department PHI. To make any amendment(s) to Department PHI that were requested by a patient and that the Department directs or agrees should be made to assure compliance with 45 CFR Section 164.526, in the time and manner designated by the Department, with the Contractor being given a minimum of twenty days within which to make the amendment.

Finding: The County does not have a process in place for addressing beneficiary PHI amendment requests in compliance with 45 CFR Section 164.526.

9.0 TECHNICAL ASSISTANCE

The County did not request any TA for this fiscal year.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

July 22, 2019

Sent via e-mail to: dutecht@co.fresno.ca.us

Dawan Utecht, Director
Fresno County Department of Behavioral Health
4441 East Kings Canyon Road
Fresno, CA 93702-3604

SUBJECT: Annual County Performance Unit Report

Dear Director Utecht:

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 Fresno 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 Fresno County's 2018-19 DMC-ODS compliance review. The report identifies deficiencies, required corrective actions, new requirements, advisory recommendations, and referrals for technical assistance.

Fresno County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 8/22/2019. 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

Substance Use Disorder
Program, Policy and Fiscal Division
County Performance Unit
P.O. Box 997413, MS 2627
Sacramento, CA 95814
http://www.dhcs.ca.gov

Distribution:

To: Director Utecht,

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 Unit Supervisor
Patricia Gulfam, Prevention Quality Assurance and Support Unit Supervisor
Katherine Anderson, Fresno County Principal Staff Analyst

Lead CPU Analyst: Jessica Jenkins **Assisting CPU Analyst(s):** Trang Huynh	**Date of Review:** 6/24/2019 - 6/25/2019 **Date of DMC-ODS Implementation:** 1/1/2019
County: Fresno	**County Address:** 3133 N. Millbrook Avenue Fresno, CA 93703
County Contact Name/Title: Katherine Anderson, Principal Staff Analyst	**County Phone Number/Email:** 559-600-6060 kathyanderson@co.fresno.ca.us
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 3133 N. Millbrook Ave, Fresno, CA on 6/17/2019. The following individuals were present:

- Representing DHCS:
  Trang Huynh, Associate Governmental Program Analyst (AGPA)
  Jessica Jenkins, AGPA

- Representing Fresno County:
  Susan Holt, Deputy Director
  Kannika Toonnachat, Division Manager
  Dawan Utecht, Director
  Katherine Anderson, Principal Staff Analyst
  Sharon Erwin, Senior Staff Analyst
  Chris Schreiber, Utilization Review Specialist
  Julie Apperson, Clinical Supervisor
  Lesby Flores, Division Manager
  Joseph Rangel, Division Manager
  Stacy VanBruggen, Division Manager
  Jeffery Robinson, Clinical Supervisor
  Cesar Rodriguez, Staff Analyst
  Aimie Rojas, Clinical Supervisor

During the Entrance Conference the following topics were discussed:

- Introductions
- Overview of the monitoring purpose and process
- County system of service overview
- Previous fiscal year CAP follow-up

Exit Conference:
An exit conference was conducted at 3133 N. Millbrook Ave, Fresno, CA on 6/18/2019. The following individuals were present:

- Representing DHCS:
  Trang Huynh, AGPA
  Jessica Jenkins, AGPA

- Representing Fresno County:
  Jolie Gordon Brower, Division Manager
  Joseph Rangel, Division Manager
  Lesby Flores, Division Manager
  Elizabeth Vasquez, Compliance Officer
  Cesar Rodriguez, Staff Analyst
  Katherine Anderson, Principal Staff Analyst
  Kannika Toonnachat, Division Manager
  Sharon Erwin, Senior Staff Analyst

During the Exit Conference the following topics were discussed:

- Review compliance deficiencies and recommendations.

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	0
6.0 Grievance, Appeal, and Fair Hearing Process	1
7.0 Quality	4
8.0 Program Integrity	2

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 deficiency in access regulations, standards, or protocol requirements was identified:

COMPLIANCE DEFICIENCY:

CD 4.24:

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 5, a-d.

5. The Contractor shall implement written policies and procedures for selection and retention of network providers and that those policies and procedures, at a minimum, meet the following requirements:
    a. Credentialing and re-credentialing requirements.
        i. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders.
        ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers.
    b. Nondiscrimination.
        i. The Contractor's network provider selection policies and procedures, consistent with 42 CFR §438.12, shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
    c. Excluded providers.
        i. The Contractor shall not employ or subcontract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.
    d. Additional Department requirements.
        i. The Contractor shall comply with any additional requirements established by the Department.

Finding: The Plan's policy and procedure is unsigned does not address the following requirement:

- Excluded providers

6.0 GRIEVANCE, APPEAL, AND FAIR HEARING

The following deficiency in grievance, appeal, and fair hearing regulations, standards, or protocol requirements was identified:

COMPLIANCE DEFICIENCY:

CD 6.37:

Intergovernmental Agreement Exhibit A, Attachment I, II. E. 7.

7. Grievance and Appeal Systems (42 CFR §438.228).
    I. The Contractor shall have in effect a grievance and appeal system that meets the requirements outlined in Article II.G of this Agreement.
    ii. The Contractor shall be responsible for issuing any Notice of Adverse Benefit Determination under 42 CFR Part 431, subpart E. The Department shall conduct random reviews of the Contractor and its providers and subcontractors to ensure that they are notifying beneficiaries in a timely manner.

MHSUD Information Notice 18-010E

Finding: The Plan's grievance and appeals procedure does not address the following requirements:

- Beneficiary may file grievance at any time,
- Resolution within 90 days from receipt of grievance,
- Beneficiary appeal filed within 60 days from date of Notice of Adverse Benefit Determination, and
- Plan must resolve expedited appeals within 72 hours of the expedited appeals request

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 meet the following requirement:

- Adopt or establishes quantitative measures to assess performance

CD 7.43:

Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 9

9. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.

Finding: The Plan did not provide evidence that they ensure the safety and effectiveness of medication practices for narcotic treatment programs and residential services.

CD 7.49:

Intergovernmental Agreement Exhibit A, Attachment I, III, LL, 10-11.

10. The Contractor shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in 42 CFR 438.240(b)(1) and (d). Performance improvement projects shall focus on a clinical area, as well as one non-clinical area.
11. PIPs shall:
    i. Measure performance using required quality indicators.
    ii. Implement system interventions to achieve improvement in quality.
    iii. Evaluate the effectiveness of interventions.
    iv. Plan and initiate activities for increasing or sustaining improvement.

Intergovernmental Agreement Exhibit A, Attachment I, III, LL, 13.

13. Each PIP shall be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care annually.

Finding: The Plan does not currently have two active Performance Improvement Projects (PIP).

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.

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:

CD 8.59:

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

i. The substance use disorder medical director's responsibilities shall at a minimum include all of the following:
   c. Develop and implement medical policies and standards for the provider..

Finding: The Plan did not provide evidence that they ensure medical policies and standards are developed by all SUD program Medical Directors.

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 procedures for detecting and preventing fraud, waste, and abuse do not address the following requirements:

- The establishment of a Regulatory Compliance Committee on the Board of Directors (County Behavioral Health Administrator) 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.
- Enforcement of standards through well-publicized disciplinary guidelines.