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

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

September 29, 2020

Sent via e-mail to: gtsai@ph.lacounty.gov

Gary Tsai, M.D., Interim Division Director
Los Angeles County Public Health Substance Abuse Prevention and Control
1000 Fremont Ave. BLDG. A-9 East, 3rd Floor, Box 34
Alhambra, CA 91803

SUBJECT: Annual County Compliance Report

Dear Director Tsai:

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 Los Angeles County.

The County Compliance Unit (CCU) within the Audits and Investigations Division (A&I) 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 Los Angeles County's State Fiscal Year 2019-20 DMC-ODS compliance review. The report identifies deficiencies, required corrective actions, new requirements, advisory recommendations, and referrals for technical assistance.

Los Angeles County is required to submit a Corrective Action Plan (CAP) addressing each compliance deficiency (CD) noted to the Medi-Cal Behavioral Health Division (MCBHD), Plan and Network Monitoring Branch (PNMB), County Monitoring Unit (CMU) Analyst by 10/29/2020. Please use the enclosed CAP form and submit the completed the CAP and supporting documentation via email to the CMU analyst at MCBHDMonitoring@dhcs.ca.gov.

If you have any questions or need assistance, please contact me at michael.bivians@dhcs.ca.gov.

Sincerely,

Michael Bivians
(916) 713-8966
michael.bivians@dhcs.ca.gov

Distribution:

To: Director Tsai,

CC: Mateo Hernandez, Audits and Investigations, Medical Review Branch Acting Chief
Lanette Castleman, Audits and Investigations, Behavioral Health Compliance Section Chief
Michael Bivians, Audits and Investigations, County Compliance Monitoring II Chief
Janet Rudnick, Audits and Investigations, Provider Compliance Unit Chief
Mayumi Hata, Medi-Cal Behavioral Health Division, County/Provider Operations and Monitoring Branch Chief
MCBHDMonitoring@dhcs.ca.gov, County and Provider Monitoring Unit
Daniel Deniz, Los Angeles County Substance Abuse Prevention and Control, Contracts and Compliance Chief

Lead CCU Analyst: Michael Bivians **Assisting CCU Analyst:** N/A	**Date of Review:** July 2020 **Date of DMC-ODS Implementation:** 7/1/2017
County: Los Angeles	**County Address:** 1000 S. Fremont Ave Bldg. A-9 East, 3rd Floor Alhambra, CA 91803
County Contact Name/Title: Daniel Deniz / Substance Abuse Prevention & Control, Contracts and Compliance Chief	**County Phone Number/Email:** 626-299-4532 ddeniz@ph.lacounty.gov
Report Prepared by: Michael Bivians	**Report Approved by:** Lanette Castleman

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. Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 438; section 438.1 through 438.930: Managed Care

II. Program Requirements:
   a. State Fiscal Year (SFY) 2019-20 Intergovernmental Agreement (IA)
   b. Mental Health and Substance Use Disorders Services (MHSUDS) Information Notices

SUMMARY OF SFY 2019-20 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	3
2.0 Member Services	0
3.0 Service Provisions	0
4.0 Access	1
5.0 Coordination of Care	0
6.0 Monitoring	3
7.0 Program Integrity	8
8.0 Compliance	3

CORRECTIVE ACTION PLAN

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

Please provide the following within the completed SFY 2019-20 CAP:

a) A statement of the CD.
b) A list of action steps to be taken to correct the CD.
c) A date of completion for each CD.
d) The name of the person who will be responsible for corrections and ongoing compliance.

The CMU liaison will monitor progress of the CAP completion.

1.0 ADMINISTRATION

A review of the administrative trainings, policies, and procedures was conducted to ensure compliance with applicable regulations and standards. The following deficiencies in administration requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 1.1:
Intergovernmental Agreement Exhibit A, Attachment I, III, A, 1, iv-v

iv. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.
v. Professional staff (LPHAs) shall receive a minimum of five (5) hours of continuing education related to addiction medicine each year.

Findings: The Plan did not provide evidence they ensure SUD program professional staff have 5 hours of continuing education units in addiction medicine annually, specifically for the following SUD programs:

- River Community Day Treatment.
- Spiritt Family Services.
- Narcotic Addiction Treatment Agency.

CD 1.3:
Intergovernmental Agreement Exhibit A, Attachment I, III, GG, 3, i

3. Training to DMC Subcontractors
    i. The Contractor shall ensure that all subcontractors receive training on the DMC-ODS requirements, at least annually. The Contractor shall report compliance with this section to DHCS annually as part of the DHCS County Monitoring process.

Findings: The Plan did not provide evidence they ensure SUD program professional staff receive training on DMC-ODS requirements annually.

CD 1.7:

Intergovernmental Agreement Exhibit A, Attachment I, 5, i, a, i-ii

i. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.
ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers.

MHSUDS Information Notice: 18-019

Effective immediately, Plans must implement and maintain written policies and procedures for the initial credentialing and re-credentialing of their providers in accordance with the policy outlined in this IN…

Credentialing Policy

For all licensed, waivered, registered and/or certified providers, the Plan must verify and document the following items through a primary source, as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by the Plan unless the Plan can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board.

1. The appropriate license and/or board certification or registration, as required for the particular provider type;
2. Evidence of graduation or completion of any required education, as required for the particular provider type;
3. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

In addition, Plans must verify and document the following information from each network provider, as applicable, but need not verify this information through a primary source:

1. Work history;
2. Hospital and clinic privileges in good standing;
3. History of any suspension or curtailment of hospital and clinic privileges;
4. Current Drug Enforcement Administration identification number;
5. National Provider Identifier number;
6. Current malpractice insurance in an adequate amount, as required for the particular provider type;
7. History of liability claims against the provider;
8. Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;
9. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network. This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp; and

10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards…

Provider Re-credentialing
DHCS requires each Plan to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above. The Plan must require each provider to submit any updated information needed to complete the re-credentialing process, as well as a new signed attestation. In addition to the initial credentialing requirements, re-credentialing should include documentation that the Plan has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, beneficiary grievances, and medical record reviews.

Findings: The Plan's policy for Credentialing and Re-Credentialing is unsigned.

4.0 ACCESS

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

COMPLIANCE DEFICIENCY:

CD 4.17:
Intergovernmental Agreement Exhibit A, Attachment I, III, JJ, 1

JJ. Subcontract Termination

1. The Contractor shall notify the Department of the termination of any subcontract with a certified provider, and the basis for termination of the subcontract, within two (2) business days. The Contractor shall submit the notification by secure, encrypted email to: SUDCountyReports@dhcs.ca.gov.

Findings: The Plan did not provide evidence they ensure a secure, encrypted email is sent to DHCS via SUDCountyReports@dhcs.ca.gov within two (2) business days when a provider's subcontract is terminated.

6.0 MONITORING

The following deficiencies in monitoring were identified:

COMPLIANCE DEFICIENCIES:

CD 6.22:
Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, ii, b

ii. For consistency in the information provided to beneficiaries, the Contractor shall use:
b. The Department developed model beneficiary handbooks and beneficiary notices.

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, iv, a-b

iv. Beneficiary information required in this section may not be provided electronically by the Contractor unless all of the following are met:
a. The format is readily accessible;
b. The information is placed in a location on the Department or the Contractor's website that is prominent and readily accessible.

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, xiv, a

a. The Contractor shall utilize, and require its subcontracted providers to utilize, the state developed model beneficiary handbook.

MHSUDS Information Notice IN 18-043

MHPs must provide each beneficiary with the beneficiary handbook when the beneficiary first accesses services, and thereafter upon request. A template for this beneficiary handbook is included as an enclosure to this IN. The content of the beneficiary handbook includes information that enables the beneficiary to understand how to effectively access specialty mental health services. The template indicates fields where the MHP should insert county-specific information. MHPs will need to edit the template to add their county-specific information where indicated in the template.

The MHP must also give each beneficiary notice of any significant change.
The information contained in the beneficiary handbook at least 30 days before the intended effective date of the change.

Information in the beneficiary handbook must include the following at a minimum:

- Benefits provided by the MHP;
- How and where to access any benefits provided by the MHP, and how transportation is provided;
- The amount, duration, and scope of benefits available under the MHP contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled;
- How beneficiaries can obtain information from the MHP about how to access services, and procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care;
- The extent to which, and how, after-hours and emergency coverage are provided;

- What constitutes an emergency medical condition and emergency services;
- The fact that prior authorization is not required for emergency services and the beneficiary has a right to use any hospital or other setting for emergency care;
- Any restrictions on the beneficiary's freedom of choice among network providers;
- The extent to which, and how, beneficiaries may obtain benefits from out-of-network providers;
- Beneficiary rights and responsibilities;
- How to exercise an advance directive;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number that is answered 24 hours a day, seven days a week that can tell beneficiaries how to access specialty mental health services;
- Information on how to report suspected fraud or abuse; and
- Any other content required by the state.

The beneficiary handbook must also contain information on the grievance, appeal, and State Hearing procedures and timeframes, including:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State Hearing after the MHP has made a determination on a beneficiary's appeal that is adverse to the beneficiary; and
- The fact that, when requested by the beneficiary, benefits that the MHP seeks to reduce or terminate will continue if the beneficiary files an appeal or requests a State Hearing within the timeframes specified for filing.

The beneficiary handbook will be considered to be provided to the beneficiary if the MHP:

- Mails a printed copy of the beneficiary handbook to the beneficiary's mailing address;
- Provides the beneficiary handbook by email after obtaining the beneficiary's agreement to receive it by email;
- Posts the beneficiary handbook on the MHP's website and advises the beneficiary in paper or electronic form that the beneficiary handbook is available on the internet, including the applicable internet address, provided that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; and/or
- Provides the beneficiary handbook by any other method that can reasonably be expected to result in the beneficiary receiving the information.

All written materials for beneficiaries, including the beneficiary handbook, must use easily understood language and format, use a font size no smaller than 12 point, be available in alternative formats, e.g. large-print in an appropriate manner that takes into consideration the special needs of beneficiaries with disabilities or limited English proficiency, and include taglines and information about how to request auxiliary aids and services, including the provision of materials in alternative formats.

Each MHP must make its written materials that are critical to obtaining services available in the prevalent non-English languages in the MHP's county, including, at a minimum, the beneficiary handbook, provider directory, appeal and grievance notices, and denial and termination notices. Written materials must also be made available in alternative formats upon request of the beneficiary at no cost. Auxiliary aids and services, such as TTY/TDY and American Sign Language, must also be made available upon request of the beneficiary at no cost. Written materials must include taglines in the prevalent non-English languages in the state, and in large-print, explaining the availability of written or oral translation to understand the information provided and the toll-free and TTY/TDY telephone number of the MHP's customer service unit. Oral interpretation must be available in all non-English languages, not just those identified as prevalent.

Findings: The Plan does not provide a Beneficiary Handbook in a format that is prominent and readily accessible. Once a beneficiary reaches the Los Angeles County Departments' web page, the beneficiary must choose between the Health Agency, Health Services and Public Health. Once the beneficiary chooses Public Health's web page, they must decide between, Clinics, Publications, Community and Health Professionals. Once the beneficiary selects the Health Professionals' web page, they must find Substance Use Prevention & Control from within a list of 22 choices located along the left column of the page. The right pathway to the handbook is more prominent on the Substance Use Prevention & Control web page.

The Beneficiary Handbook can be accessed via a desktop or laptop after eight (8) clicks from the County of Los Angeles website as follows:

1. Government;
2. Departments, Commissions & Related Agencies;
3. Los Angeles County Departments;
4. Public Health;
5. Health Professionals;
6. Substance Use Prevention & Control
7. Patients and Public; and
8. Patient Handbook.

The Beneficiary Handbook can be accessed via a mobile device after nine (9) clicks from the County of Los Angeles website as follows:

1. Menu;
2. Government;
3. Departments, Commissions & Related Agencies;
4. Los Angeles County Departments;
5. Public Health;
6. Health Professionals;
7. Substance Use Prevention & Control
8. Patients and Public; and
9. Patient Handbook.

CD 6.23:

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, iv, a-b

iv. Beneficiary information required in this section may not be provided electronically by the Contractor unless all of the following are met:
   a. The format is readily accessible;
   b. The information is placed in a location on the Department or the Contractor's website that is prominent and readily accessible.

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, xviii, a

a. The Contractor shall make available in electronic form and, upon request, in paper form, the following information about its network providers:
   i. The provider's name as well as any group affiliation;
   ii. Street address(es);
   iii. Telephone number(s);
   iv. Website URL, as appropriate;
   v. Specialty, as appropriate;
   vi. Whether the provider will accept new beneficiaries;
   vii. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training; and
   viii. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

MHSUDS Information Notice 18-020

…the provider directory must also include the following information for each rendering provider:
- Type of practitioner, as appropriate;
- National Provider Identifier number;
- California license number and type of license; and,
- An indication of whether the provider has completed cultural competence training.

The provider directory should also include the following notation (may be included as a footnote); "Services may be delivered by an individual provider, or a team of providers, who is working under the direction of a licensed practitioner operating within their scope of practice. Only licensed, waivered, or registered mental health providers and licensed substance use disorder services providers are listed on the Plan's provider directory."

Plans may choose to delegate the requirement to list individuals employed by provider organizations to its providers. If the Plan delegates this requirement, the Plan's website must link to the provider organization's website and vice versa. Alternately, the Plan may elect to maintain this information at the county level. Ultimately, the Plan maintains responsibility for monitoring the network provider's compliance with these requirements.

Findings: The Plan does not provide a Provider Directory in a format that is prominent and readily accessible. Once a beneficiary reaches the Los Angeles County Departments' web page, the beneficiary must choose between the Health Agency, Health Services and Public Health. Once the beneficiary chooses Public Health's web page, they must decide between, Clinics, Publications,

Community and Health Professionals. Once the beneficiary selects the Community web page, the beneficiary must click on the Find Treatment link that will open up the Provider Directory.

Another access point for the Find Treatment link into the Provider Directory can be found through the Substance Use Prevention and Control web page, which requires navigation through two additional web pages.

The Beneficiary Handbook can be accessed via a desktop or laptop after six (6) clicks from the County of Los Angeles website as follows:

1. Government;
2. Departments, Commissions & Related Agencies;
3. Los Angeles County Departments;
4. Public Health;
5. Community; and
6. Find Treatment (Provider Directory).

The Beneficiary Handbook can be accessed via a mobile device after seven (7) clicks from the County of Los Angeles website as follows:

1. Menu;
2. Government;
3. Departments, Commissions & Related Agencies;
4. Los Angeles County Departments;
5. Public Health;
6. Community; and
7. Find Treatment (Provider Directory).

CD 6.25:
Intergovernmental Agreement Exhibit A, Attachment I, III, OO, 1, i, d

1. Monitoring
   i. Contractor's performance under this Exhibit A, Attachment I, shall be monitored by DHCS annually during the term is the Agreement. Monitoring criteria shall include, but not be limited to:
      d. Contractor shall conduct annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of their monitoring and audit reports to DHCS within two weeks of issuance. Reports should be sent by secure, encrypted e-mail to:
         sudcountyreports@dhcs.ca.gov

         Alternatively, mail to:
         Department of Health Care Services
         Audits and Investigations Division
         Medical Review Branch
         Behavioral Health Compliance Section
         County Compliance Unit
         1500 Capitol Ave., MS 2305
         Sacramento, CA 95814

Findings: The Plan did not monitor all county and subcontracted providers for compliance with DMC-ODS programmatic and fiscal requirements. Specifically:

- For SFY 2018-19, the Plan monitored 169 of 226 Plan and sub-contracted providers for DMC-ODS programmatic and fiscal requirements, and submitted audit reports of these monitoring reviews to DHCS.
- The Plan submitted 96 of 169 DMC-ODS audit reports to DHCS within two weeks of report issuance.

7.0 PROGRAM INTEGRITY

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

COMPLIANCE DEFICIENCIES:

CD 7.38:
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 Agreement, 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 County Behavioral Health Director and the Board of Supervisors.
        iii. The establishment of a Regulatory Compliance Committee on the Board of Supervisors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Agreement.
        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 Agreement.
        v. Effective lines of communication between the compliance officer and the organization's employees.
        vi. Enforcement of standards through well-publicized disciplinary guidelines.
        vii. 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.

Findings: The Plan did not provide evidence of a written policy, procedure or standard of conduct that ensures procedures to detect and prevent Fraud, Waste and Abuse have the required elements as follows:

- Designation of a Compliance Officer.
- A system for training and education for the Compliance Officer.
- Effective lines of communication between the Compliance Officer and the Plan's network providers' employees.
- Establishment of a Regulatory Compliance Committee.
- Enforcement of standards through well-publicized disciplinary guidelines.
- Must have procedures for monitoring and auditing for compliance.

CD 7.40:

Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, ii, a, v

i. The arrangements or procedures shall include the following:
   a. A compliance program that includes, at a minimum, all of the following elements:
      v. Effective lines of communication between the compliance officer and the organization's employees.

Findings: The Plan did not provide evidence to show how it ensures effective communication between its' Compliance Officer and the organization's employees.

CD 7.41:

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

ii. The arrangements or procedures shall include the following:
   b. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.
   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.

Findings: The Plan did not provide evidence to show how it ensures prompt reporting of all overpayments to DHCS including provisions for referral of any potential fraud, waste and abuse identified by the Plan to DHCS's Medicaid Fraud Control Unit.

CD 7.42:

Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, v, b

v. Treatment of recoveries made by the Contractor of overpayments to providers.
   b. The Contractor shall have a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.

Findings: The Plan did not provide evidence to show how it ensures network providers properly return overpayments made by the Plan within 60 days of identification.

CD 7.43:

Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, v, c

v. Treatment of recoveries made by the Contractor of overpayments to providers.
   c. The Contractor shall annually report to the Department on their recoveries of overpayments.

MHSUDS Information Notice 19-022

Consistent with Exhibit A, Attachment I of the Intergovernmental Agreement (IA), DMC-ODS counties must submit a completed and signed certification statement on county letterhead to ODSSubmissions@dhcs.ca.gov. The certification is required with each submission of the following data, documentation, and information:

- Annual report of overpayment recoveries;

The certification statement must be on county letterhead and conform to the following requirements:

- Indicate the current month during which all data, information, and documentation submitted to DHCS, as described above, is certified;
- Reference, with specificity, all types of data, information, and documentation described in the bulleted list above; and
- State that the data, information, and documentation to which the certification statement applies is “accurate, complete, and truthful” to the declarant’s “best information, knowledge, and belief.”

The Chief Executive Officer (CEO), the Chief Financial Officer (CFO), or an individual who reports to the CEO or CFO with the delegated authority to sign for the CEO or CFO, so that the CEO or CFO is ultimately responsible for the certification, must sign the certification statement. The attached DMC-ODS County Certification template includes the requirements described above.

Findings: The Plan did not provide evidence of a signed policy to ensure overpayments are properly communicated to DHCS.

CD 7.44:
Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 6, i-ii

i. The SUD 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 written 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, and 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 SUD Medical Director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

Findings: The written roles and responsibilities provided for the Long Beach Recovery Center's Medical Director is missing the following criteria:

- Develop and implement written medical policies and standards for the provider.

The written roles and responsibilities provided for the Children's Hospital of Los Angeles Medical Director is missing the following criteria:

- Ensure that physicians do not delegate their duties to non-physician personnel.
- Develop and implement written medical policies and standards for the provider.
- Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.

CD 7.45:

Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 7, iii, a-i

iii. Written provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
   a. Use of drugs and/or alcohol.
   b. Prohibition of social/business relationship with beneficiaries or their family members for personal gain.
   c. Prohibition of sexual contact with beneficiaries.
   d. Conflict of interest.
   e. Providing services beyond scope.
   f. Discrimination against beneficiaries or staff.
   g. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff.
   h. Protection of beneficiary confidentiality.
   i. Cooperate with complaint investigations.

Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 7, 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.

Findings: The Plan's Los Angeles County Department of Public Health's Medical Director Code of Conduct is missing the following elements:

- Conflict of interest.
- Providing services beyond scope.
- Cooperate with complaint investigations.

The Plan's House of Hope's Medical Director Code of Conduct is missing the following elements:

- Providing services beyond scope.
- Shall be clearly documented, signed and dated by a provider representative and the physician.

The Plan's Van Ness Recovery Home's Medical Director Code of Conduct is missing the following elements:

- Use of drugs and/or alcohol.
- Shall be clearly documented, signed and dated by a provider representative and the physician.

The Plan's Pasadena Council on Alcoholism and Drug Dependence's Medical Director Code of Conduct is missing the following elements:

- Use of drugs and/or alcohol.
- Prohibition of social/business relationship with beneficiaries or their family members for personal gain.
- Prohibition of sexual contact with beneficiaries.
- Providing services beyond scope.
- Discrimination against beneficiaries or staff.
- Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff.

- Cooperate with complaint investigations.
- Shall be clearly documented, signed and dated by a provider representative and the physician.

CD 7.46:

Intergovernmental Agreement Exhibit A, Attachment I, III, AA, 1-2 iv

1. In addition to complying with the subcontractual relationship requirements set forth in Article II E 8 of this Agreement, the Contractor shall ensure that all subcontracts require that the Contractor oversee and is held accountable for any functions and responsibilities that the Contractor delegates to any subcontractor.
2. Each subcontract shall:
   iv. Ensure the Contractor monitors the subcontractor's performance on an ongoing basis and subject it to an annual onsite review, consistent with statutes, regulations, and Article III.PP.

Intergovernmental Agreement Exhibit A, Attachment I, III, FF, 4, i, c-f

i. The CalOMS-Tx business rules and requirements are:
   c. 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.
   d. 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.
   e. 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.
   f. 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.

Findings: The following CalOMS-Tx reports are non-compliant:

- Open Admissions Report.
- Open Providers Report.

8.0 COMPLIANCE

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

COMPLIANCE DEFICIENCIES:

CD 8.48:
MHSUDS Information Notice IN 18-020
Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, iv, a-b
Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, xviii, a-d

Findings: The Plan's Provider Directory contained providers missing the following elements:

- Street address(s).
- Specialty, as appropriate.
- Whether the provider will accept new beneficiaries.
- The provider's cultural capabilities.
- The provider's Linguistic capabilities.
- ADA compliant.
- Type of practitioner, as appropriate.
- National Provider Identifier number.
- California license type and number.
- Completed cultural competence training.

CD 8.56

Intergovernmental Agreement Exhibit A, Attachment I, III, Y, 8, ii, v, a

a. The Contractor agrees to cure transactions errors or deficiencies identified by DHCS, and transactions errors or deficiencies identified by an enrolled provider if the Contractor is acting as a clearinghouse for that provider. If the Contractor is a clearinghouse, the Contractor agrees to properly communicate deficiencies and other pertinent information regarding electronic transactions to enrolled providers for which they provide clearinghouse services.

Findings: The Plan has not resolved previous deficiencies identified by DHCS in SFY 2018-19, CD 7.50; specifically the Open Admissions Report and the Open Providers Report are not in compliance.

CD 8.59

Intergovernmental Agreement Exhibit A, Attachment I, III, Y, 8, ii, v, a

a. The Contractor agrees to cure transactions errors or deficiencies identified by DHCS, and transactions errors or deficiencies identified by an enrolled provider if the Contractor is acting as a clearinghouse for that provider. If the Contractor is a clearinghouse, the Contractor agrees to properly communicate deficiencies and other pertinent information regarding electronic transactions to enrolled providers for which they provide clearinghouse services.

Findings: The Plan has not resolved previous deficiencies identified by DHCS in SFY 2018-19, CD 8.58; specifically the Plan did not provide evidence the Medical Director of Serenity House had written Roles and Responsibilities and a Code of Conduct with all required elements.

TECHNICAL ASSISTANCE

Los Angeles County did not request Technical Assistance during this review.