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: JConnolly@ph.lacounty.gov

John M. Connolly, Ph.D., M.S.Ed., Division Director
Los Angeles County Department of Public Health
Substance Abuse Prevention and Control
1000 South Fremont Ave.
Building A-9 East, Third Floor
Alhambra, CA 91803

SUBJECT: Annual County Performance Unit Report

Dear Director Connelly:

The Department of Health Care Services (DHCS) is responsible for monitoring compliance to requirements of the Substance Abuse Block Grant (SABG) Contract operated by Los Angeles 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 Los Angeles County's 2018-19 SABG Contract compliance review. The report identifies deficiencies, required corrective actions, advisory recommendations, and referrals for technical assistance.

Los Angeles 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

Distribution:

To: Director Connolly

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
Daniel Deniz, Chief, Los Angeles County Contracts and Compliance

Lead CPU Analyst: Trang Huynh **Assisting CPU Analyst(s):** Jessica Jenkins LaMonte Love	**Date of Review:** 6/4/2019 - 6/5/2019
County: Los Angeles	**County Address:** 1000 South Fremont Ave. Building A-9 East, Third Floor Alhambra, CA 91803
County Contact Name/Title: Daniel Deniz, Chief	**County Phone Number/Email:** (626) 299-4532 ddeniz@ph.lacounty.gov
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 1000 S. Freemont Ave, 3rd Floor Alhambra, CA 91803 on 6/4/2019. The following individuals were present:

- Representing DHCS:
  Jessica Jenkins, Associate Governmental Program Analyst (AGPA)
  Trang Huynh, AGPA
  LaMonte Love, AGPA
  Janet Rudnick, Staff Services Manager II (SSM II)

- Representing Los Angeles County:
  Antonne Moore, Chief Marketing and Beneficiary Engagement Unit
  Michelle Gibson, Acting Deputy Division Director for Treatment Services
  Daniel Deniz, Chief Contracts and Grants
  Ruth Kantorwicz, Staff Analyst
  Keith Hermanstyne, Associate Medical Director for Treatment Services
  Kristine Glaze, CENS Manager
  Akbar Saddiq, Information Systems Analyst
  Vu Pham, Senior Information Systems Analyst
  Stephanie Chen, Senior Staff Analyst
  Gary Tsai, Medical Director
  John Connolly, Division Director

During the Entrance Conference the following topics were discussed:

- Overview of the monitoring purpose and process
- The site review agenda

Exit Conference:
An exit conference was conducted at 1000 S. Freemont Ave, 3rd Floor Alhambra, CA 91803 on 6/5/2019. The following individuals were present:

- Representing DHCS:
  Jessica Jenkins, AGPA
  Trang Huynh, AGPA
  LaMonte Love, AGPA
  Janet Rudnick, SSM II

- Representing Los Angeles County:
  Daniel Deniz, Chief of Contracts and Grants
  Ruth Kantorwicz, Staff Analyst
  Michelle Gibson, Acting Deputy Division Director for Treatment Services

During the Exit Conference the following topics were discussed:

- Compliance deficiencies

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	2
2.0 SABG Monitoring	2
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	3
8.0 Privacy and Information Security	2

PREVIOUS CAPs

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

2014-15:

CD # 13: Open Admissions
Finding: The County and its providers' annual updates or client discharges for beneficiaries in treatment over one year were not submitted.
County Reason for non-clearance of CD: The County cites having issues with maintaining an accurate Master Provider File (MPF) and needing to remove several providers from their MPF. Additionally, the County indicated switching to a new Electronic Health Record system as a reason for non-clearance, as many providers have not yet switched over to the new system.
County plan to remediate: The County plans to continue to work with DHCS and the MPF team to correct their Master Provider File. They are also working with their vendor NetSmart to submit data to CalOMS. Additionally, the County stated they have not implemented a Corrective Action Plan (CAP) for providers that fail to submit data. The county requests Technical Assistance from DHCS in resolving this deficiency and was given a recommendation to contact SUD CalOMS Support. The County committed to do the following, monthly, until this deficiency is resolved:

- Remove old records;
- Upload new data to CalOMS;
- Identify active/non-active facilities; and
- Collaborate with NetSmart to submit the correct data

Original expected date of completion: July 2015
Updated/ revised date of completion: December 2019

CD # 14: Open Providers
Finding: The County and its providers did not report CalOMS Tx data, and did not generate a Provider No Activity (PNA) report.
Reason for non-clearance of CD: The county reports having issues with Net Smart, in addition to not making CalOMS a priority.
County plan to remediate: The County will work with NetSmart to correct the issue, as well as work internally to ensure CalOMS is monitored by both compliance and IT staff.
Original expected date of completion: July 2015
Updated/ revised date of completion: December 2019

On June 11, 2019, a conference call was held with the County and DHCS. The County indicated they have internal data that needs to be uploaded to CalOMS. Division Chief Don Braeger relayed to the County that all CalOMS data issues need to be resolved before December 2019. DHCS confirms there are no issues on the Department's end regarding the County's MPF.

CD #15: DATAR
Finding: The County and its providers do not submit DATAR reports by the 10th of each month.
Reason for non-clearance of CD: The County has issues monitoring their data.
County plan to remediate: The County cites cleaning up the MPF as a way to remediate this deficiency.
Original expected date of completion: July 2015
Updated/revised date of completion: December 2019

2015-16:

CD #5: Open Admissions
County's response: Please see CD #13
Reason for non-clearance of CD: Please see CD #13
County plan to remediate: Please see CD #13
Original expected date of completion: July 2015
Updated/revised date of completion: December 2019

CD # 6: Open Providers
County's response: Please see CD #14
Reason for non-clearance of CD: Please see CD #14
County plan to remediate: Please see CD #14
Original expected date of completion: July 2015
Updated/revised date of completion: December 2019

CD # 7: DATAR
County's response: Please see CD #15
Reason for non-clearance of CD: Please see CD #15
County plan to remediate: Please see CD #15
Original expected date of completion: July 2015
Updated/revised date of completion: December 2019

2016-17:

CD # 10.57.b: **Open Providers**
County's response: Please see CD #14
Reason for non-clearance of CD: Please see CD #14
County plan to remediate: Please see CD #14
Original expected date of completion: October 2017
Updated/revised date of completion: December 2019

CD # 10.57.d: Open Admissions
County's response: Please see CD #13
Reason for non-clearance of CD: Please see CD #13
County plan to remediate: Please see CD #13
Original expected date of completion: October 2017
Updated/revised date of completion: December 2019

2017-18:

CD # 7.41 a: Open Admissions
Finding: The County's open admissions report is not current
Reason for non-clearance of CD: Please see CD #13
County plan to remediate: Please see CD #13
Original expected date of completion: November 2018
Updated/revised date of completion: December 2019

CD # 7.41 b: Open Providers
Finding: The County's open providers report is not current
Reason for non-clearance of CD: Please see CD #14
County plan to remediate: Please see CD #14
Original expected date of completion: November 2018
Updated/revised date of completion: December 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 deficiencies in regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 1.5:

SABG State-County Contract Exhibit A, Attachment I AI, Part II, B
Hatch Act: Contractor agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

SABG State-County Contract Exhibit A, Attachment I AI, Part II, Y
Subcontract Provisions: Contractor shall include all of the foregoing Part II general provisions in all of its subcontracts.

Finding: The County did not demonstrate subcontractor staff compliance with the Hatch Act.

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.

2.0 SABG MONITORING

The following deficiencies in the SABG monitoring requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 2.9:

SABG State-County Contract Exhibit A, Attachment I A1, Part I, Section 3, A, 1, (e)
Contractor's performance under this Exhibit A, Attachment I, Part I, shall be monitored by DHCS during the term of this Contract. Monitoring criteria shall include, but not be limited to:

e) Whether the Contractor conducted annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of its monitoring and audit reports to DHCS within two weeks of issuance. Reports shall be sent by secure, encrypted email to:
SUDCountyReports@dhcs.ca.gov or Substance Use Disorder-Program, Policy, and Fiscal Division
Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2627
Sacramento, CA 95899-7413

Finding: The County did not monitor all County providers for all SABG program and fiscal requirements.

CD 2.15:

SABG State-County Contract Exhibit A, Attachment I A1, Part I, Section 3, A, 1 (a-e)
Contractor's performance under this Exhibit A, Attachment I, Part I, shall be monitored by DHCS during the term of this Contract. Monitoring criteria shall include, but not be limited to: a) Whether the quantity of work or services being performed conforms to Exhibit B.
b) Whether the Contractor has established and is monitoring appropriate quality standards.
c) Whether the Contractor is abiding by all the terms and requirements of this Contract.
d) Whether the Contractor is abiding by the terms of the Perinatal Services Network Practice Guidelines (Document 1G).
e) Whether the Contractor conducted annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of its monitoring and audit reports to DHCS within two weeks of issuance. Reports shall be sent by secure, encrypted email to:

SUDCountyReports@dhcs.ca.gov or Substance Use Disorder-Program, Policy, and Fiscal Division
Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2627
Sacramento, CA 95899-7413

Finding: The County did not submit all of their SABG monitoring reports for SFY 17-18 to DHCS within two weeks of report issuance.

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.

CD 7.34.c:

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, E, (1) & (3)

(1) The Contractor shall be responsible for ensuring that the Contractor-operated treatment services and all treatment providers, with whom Contractor makes a contract or otherwise pays for these services, submit a monthly DATAR report in an electronic copy format as provided by DHCS.

(3) The Contractor shall ensure that all DATAR reports are submitted by either Contractor- operated treatment services and by each subcontracted treatment provider to DHCS by the 10th of the month following the report activity month.

Finding: The County's DATAR report is not current.

8.0 PRIVACY AND INFORMATION SECURITY

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

COMPLIANCE DEFICIENCIES:

CD 8.36:

SABG State-County Contract, Exhibit F, F-1, 3, D, 13 (d)
Responsibility for Reporting of Breaches. If the cause of a breach of Department PHI is attributable to Contractor or its agents, subcontractors or vendors, Contractor is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary (after obtaining prior written approval of DHCS). If a breach of unsecured Department PHI involves more than 500 residents of the State of California or under its jurisdiction, Contractor shall first notify DHCS, then the Secretary of the breach immediately upon discovery of the breach. If a breach involves more than 500 California residents, Contractor shall also provide, after obtaining written prior approval of DHCS, notice to the Attorney General for the State of California, Privacy Enforcement Section. If Contractor has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents, or vendors may report the breach or incident to the Department in addition to Contractor, Contractor shall notify the Department, and the Department and Contractor may take appropriate action to prevent duplicate reporting.

SABG State-County Contract, Exhibit F, F-1, 3, D, 7, b (i-ii)
In accordance with 45 CFR Section 164.504(e)(1)(ii), upon Contractor's knowledge of a material breach or violation by its subcontractor of the agreement between Contractor and the subcontractor, Contractor shall:
i) Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by the Department; or
ii) Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

Finding: The County does not have a process in place to ensure subcontractors notify the County of any material breach or violation.

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.

10.0 TECHNICAL ASSISTANCE

The County did not request 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: JConnolly@ph.lacounty.gov

John M. Connolly, Ph.D., M.S. Ed., Division Director
1000 South Fremont Avenue, Building A-9 East
3rd Floor, Box 34
Alhambra, California 91803

SUBJECT: Annual County Performance Unit Report

Dear Director Connolly:

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 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 Los Angeles County's 2018-19 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 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 Connolly

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
Daniel Deniz, Los Angeles County Chief of Contracts and Compliance

Lead CPU Analyst: Jessica Jenkins **Assisting CPU Analyst(s):** LaMonte Love	**Date of Review:** 6/4/2019 - 6/5/2019 **Date of DMC-ODS Implementation:** 7/1/2017
County: Los Angeles	**County Address:** 1000 South Fremont Avenue, Building A-9 East 3rd Floor, Box 34 Alhambra, California 91803
County Contact Name/Title: Daniel Deniz/Chief Contracts & Compliance	**County Phone Number/Email:** (626) 299-4532 ddeniz@ph.lacounty.gov
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 1000 S. Freemont Ave, 3rd Floor Alhambra, CA 91803 on 6/4/2019. The following individuals were present:

- Representing DHCS:
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  Antonne Moore, Chief Marketing and Beneficiary Engagement Unit
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  Daniel Deniz, Chief Contracts and Compliance
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  Akbar Saddiqui, Information Systems Analyst
  Vu Pham, Senior Information Systems Analyst
  Stephanie Chen, Senior Staff Analyst
  Gary Tsai, Medical Director
  John Connolly, Division Director

During the Entrance Conference the following topics were discussed:

- Overview of the monitoring purpose and process
- The site review agenda

Exit Conference:
An exit conference was conducted at 1000 S. Freemont Ave, 3rd Floor Alhambra, CA 91803 on 6/5/2019. The following individuals were present:

- Representing DHCS:
  Jessica Jenkins, AGPA
  Trang Huynh, AGPA
  LaMonte Love, AGPA
  Janet Rudnick, SSM II

- Representing Los Angeles County:
  Daniel Deniz, Chief of Contracts and Grants
  Ruth Kantorwicz, Staff Analyst
  Michelle Gibson, Acting Deputy Division Director for Treatment Services

During the Exit Conference the following topics were discussed:

- Compliance deficiencies
- Recommendations

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	0
2.0 Member Services	2
3.0 Service Provisions	0
4.0 Access	2
5.0 Continuity and Coordination of Care	0
6.0 Grievance, Appeal, and Fair Hearing Process	1
7.0 Quality	3
8.0 Program Integrity	6

PREVIOUS CAPs

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

2014-15:

CD # 13: Open Admissions
Finding: The County and its providers' annual updates or client discharges for beneficiaries in treatment over one year were not submitted.
County Reason for non-clearance of CD: The County cites having issues with maintaining an accurate Master Provider File (MPF) and needing to remove several providers from their MPF. Additionally, the County indicated switching to a new Electronic Health Record system as a reason for non-clearance, as many providers have not yet switched over to the new system.
County plan to remediate: The County plans to continue to work with DHCS and the MPF team to correct their Master Provider File. They are also working with their vendor NetSmart to submit data to CalOMS. Additionally, the County stated they have not implemented a Corrective Action Plan (CAP) for providers that fail to submit data. The county requests Technical Assistance from DHCS in resolving this deficiency and was given a recommendation to contact SUD CalOMS Support. The County committed to do the following, monthly, until this deficiency is resolved:

- Remove old records;
- Upload new data to CalOMS;
- Identify active/non-active facilities; and
- Collaborate with NetSmart to submit the correct data

Original expected date of completion: July 2015
Updated/ revised date of completion: December 2019

CD # 14: Open Providers
Finding: The County and its providers did not report CalOMS Tx data, and did not generate a Provider No Activity (PNA) report.
Reason for non-clearance of CD: The county reports having issues with Net Smart, in addition to not making CalOMS a priority.
County plan to remediate: The County will work with NetSmart to correct the issue, as well as work internally to ensure CalOMS is monitored by both compliance and IT staff.
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CD #15: DATAR
Finding: The County and its providers do not submit DATAR reports by the 10th of each month.
Reason for non-clearance of CD: The County has issues monitoring their data.

County plan to remediate: The County cites cleaning up the MPF as a way to remediate this deficiency.
Original expected date of completion: July 2015
Updated/revised date of completion: December 2019

2015-16:

CD #5: Open Admissions
County's response: Please see CD #13
Reason for non-clearance of CD: Please see CD #13
County plan to remediate: Please see CD #13
Original expected date of completion: July 2015
Updated/revised date of completion: December 2019

CD # 6: Open Providers
County's response: Please see CD #14
Reason for non-clearance of CD: Please see CD #14
County plan to remediate: Please see CD #14
Original expected date of completion: July 2015
Updated/revised date of completion: December 2019

CD # 7: DATAR
County's response: Please see CD #15
Reason for non-clearance of CD: Please see CD #15
County plan to remediate: Please see CD #15
Original expected date of completion: July 2015
Updated/revised date of completion: December 2019

2016-17:

CD # 10.57.b: **Open Providers**
County's response: Please see CD #14
Reason for non-clearance of CD: Please see CD #14
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County's response: Please see CD #13
Reason for non-clearance of CD: Please see CD #13
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2017-18:

CD # 7.41 a: Open Admissions
Finding: The County's open admissions report is not current
Reason for non-clearance of CD: Please see CD #13
County plan to remediate: Please see CD #13
Original expected date of completion: November 2018
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CD # 7.41 b: Open Providers
Finding: The County's open providers report is not current
Reason for non-clearance of CD: Please see CD #14
County plan to remediate: Please see CD #14
Original expected date of completion: November 2018
Updated/revised date of completion: December 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.

2.0 MEMBER SERVICES

The following deficiencies in the member services requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 2.10:

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 xvii, a.

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

Finding: The Plan did not provide evidence the Plan's beneficiary handbook in available in all County threshold languages.

CD 2.14:

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, xv, a-c.

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
   viiii. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

b. The Contractor shall include the following provider types covered under this Agreement in the provider directory:
   i. Physicians, including specialists
   ii. Hospitals
   iii. Pharmacies
   iv. Behavioral health providers

c. Information included in a paper provider directory shall be updated at least monthly and electronic provider directories shall be updated no later than 30 calendar days after the Contractor receives updated provider information.

MHSUDS Information Notice: 18-020
I. Provider Directory Content

Each Plan's provider directory must make available in electronic form, and paper form upon request, the following information for all network providers, including each licensed, waivered, or registered mental health provider and licensed substance use disorder services provider employed by the Plan, each provider organization or individual practitioner contracting with the Plan, and each licensed, waivered, or registered mental health provider and licensed substance use disorder services provider employed by a provider organization to deliver Medi-Cal services:

- The provider's name and group affiliation, if any;
- Provider's business address(es) (e.g., physical location of the clinic or office);
- Telephone number(s);
- Email address(es), as appropriate;
- Website URL, as appropriate;
- Specialty, in terms of training, experience and specialization, including board certification (if any);
- Services / modalities provided, including information about populations served (i.e., perinatal, children/youth, adults);
- Whether the provider accepts new beneficiaries;
- The provider's cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender);
- The provider's linguistic capabilities including languages offered (e.g., Spanish, Tagalog, American Sign Language) by the provider or a skilled medical interpreter at the provider's office; and,
- Whether the provider's office / facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.
- In addition to the information listed above, 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.

Finding: The provider directory is missing the following required elements:

- Whether the provider's office / facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.
- The following required language: "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."

4.0 ACCESS

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

COMPLIANCE DEFICIENCIES:

CD 4.26:

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 5. a. i – ii.

i. 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.

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.

Finding: The Plan does not have a policy and procedure in place to address credentialing and re-credentialing of network providers.

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.

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.

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

- Beneficiary may file grievance at any time
- For termination, suspension, or reduction of previously authorized services – at least 10 days before date of action
- For denial of payment – at the time of any action denying the providers claim
- For denial, delay, or modification decisions within two (2) business days of decision

7.0 QUALITY

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

COMPLIANCE DEFICIENCIES:

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's Quality Improvement (QI) Plan does not include the following requirements for FY 18/19:

- Timeliness of first initial contact to face-to-face appointment
- Frequency of follow-up appointments in accordance with individualized treatment plans
- Timeliness of services of the first dose of NTP services
- Access to after-hours care
- Responsiveness of the beneficiary access line
- Strategies to reduce avoidable hospitalizations
- Coordination of physical and mental health services with waiver services at the provider level
- Assessment of the beneficiaries' experiences
- Telephone access line and services in the prevalent non-English languages

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

CD 7.51:

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

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.
   v. Ensure that the Contractor identifies deficiencies or areas for improvement, the subcontractor shall take corrective actions and the Contractor shall ensure that the subcontractor implements these corrective actions.

Finding: The Plan does not require corrective actions when providers do not submit CalOMS Tx data timely.

8.0 PROGRAM INTEGRITY

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

COMPLIANCE DEFICIENCIES:

CD 8.55:

Intergovernmental Agreement Exhibit A, Attachment I, III, BB, 2, ii.

ii. Contractor and subcontractors that provide DMC services shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services DMC Provider Billing Manual.

Finding: The Plan does not require providers to determine beneficiary DMC eligibility monthly.

CD 8.58:

Intergovernmental Agreement Exhibit A, Attachment I, III. PP, 6, 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, 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.

Finding: The written roles and responsibilities, and code of conduct did not meet the following requirements:

- Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care
- Ensure that physicians do not delegate their duties to non-physician personnel
- Develop and implement medical policies and standards for the provider
- Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards
- Ensure that the medical decisions made by physicians are not influenced by fiscal considerations
- 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
- Ensure that provider's physicians are adequately trained to perform other physician duties

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 submit evidence that medical policies and standards developed by all provider Medical Directors is required.

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 submit results of investigations to the SUDCountyReports mailbox within two (2) business days.

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.

CD 8.64:

Intergovernmental Agreement Exhibit A, Attachment I, II, H, 3, I, d.

iii. The Contractor shall submit to the Department the following data:
The annual report of overpayment recoveries as required in 42 CFR §438.608(d)(3).

42 CFR §438.608(d).
Treatment of recoveries made by the MCO, PIHP or PAHP of overpayments to providers.
Contracts with a MCO, PIHP, or PAHP must specify:
The retention policies for the treatment of recoveries of all overpayments from the MCO, PIHP, or PAHP to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

ii. The process, timeframes, and documentation required for reporting the recovery of all overpayments.
iii. The process, timeframes, and documentation required for payment of recoveries of overpayments to the State in situations where the MCO, PIHP, or PAHP is not permitted to retain some or all of the recoveries of overpayments.

Finding: The Plan did not provide a copy of the written procedure for the prompt reporting of all overpayments identified or recovered to DHCS.