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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

June 21, 2019

Sent via e-mail to: JAfrica@marincounty.net

Jei Africa, PsyD, MSCP, CATC-V, Director
Marin County Dept. of Health & Human Services
Division of Mental Health & Substance Use Services
20 North San Pedro Road, Room 2021
San Rafael, CA 94903-4158

SUBJECT: Annual County Performance Unit Report

Dear Director Africa,

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

Marin County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 7/22/2019. 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,

Michael Bivians

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

Distribution:

To: Director Africa,

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
Catherine Condon, MPA, AOD Administrator

Lead CPU Analyst: Michael Ulibarri **Assisting CPU Analyst(s):** Mike Bivians LaMonte Love Joel Case	**Date of Review:** 5/2/2019
County: Marin County	**County Address:** 20 North San Pedro Road, Room 2021 San Rafael, CA 94903-4158
County Contact Name/Title: Jei Africa / Director Catherine Condon / Administrator	**County Phone Number/Email:** (415) 473-7595 / JAfrica@marincounty.net (415) 473-4218 / Ccondon@marincounty.org
Report Prepared by: Mike Bivians	**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 via teleconference on 5/2/2019. The following individuals were present:

- Representing DHCS:
  Michael Ulibarri, Assistant Governmental Program Analyst (AGPA)
  Mike Bivians, AGPA
  LaMonte Love, AGPA
  Joel Case, AGPA
  Cynthia Hudgins, Staff Services Manager II

- Representing Marin County:
  Jei Africa, CATC-V, Director
  Catherine Condon, AOD Administrator
  David Rothery, Compliance Officer

During the Entrance Conference the following topics were discussed:

- Introductions of both the DHCS and Marin County representatives present at the meeting.
- An overview of how the review would be conducted was provided by DHCS.
- Preliminary questions and concerns were fielded.

Exit Conference:
An exit conference was conducted via teleconference on 5/21/2019. The following individuals were present:

- Representing DHCS:
  Michael Ulibarri, AGPA
  Mike Bivians, AGPA
  LaMonte Love, AGPA
  Joel Case, AGPA
  Cynthia Hudgins, SSMII

- Representing Marin County:
  Jei Africa, CATC-V, Director
  Catherine Condon, AOD Administrator
  David Rothery, Compliance Officer

During the Exit Conference the following topics were discussed:

- A review of the county's tentative deficiencies was presented by DHCS.
- Follow-up on a list of items needing further research by DHCS.

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	1
2.0 SABG Monitoring	1
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	1
8.0 Privacy and Information Security	0

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 1.5:

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 County and subcontractor staff compliance with the Hatch Act.

2.0 SABG MONITORING

The following deficiency in the SABG monitoring requirements were identified:

COMPLIANCE DEFICIENCY:

CD 2.10:

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 provide evidence they ensure compliance with the following:
Trafficking Victims Protection Act

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.b:

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

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

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

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

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

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

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

9.0 TECHNICAL ASSISTANCE

DHCS's County Performance Analyst will make referrals for the training and/or technical assistance identified below.

No Technical Assistance was requested.

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

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June 21, 2019

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Jei Africa, PsyD, MSCP, CATC-V, Director
Marin County Dept. of Health & Human Services
Division of Mental Health & Substance Use Services
20 North San Pedro Road, Room 2021
San Rafael, CA 94903-4158

SUBJECT: Annual County Performance Unit Report

Dear Director Africa,

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

Marin County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 7/22/2019. 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,

Michael Bivians

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

Distribution:

To: Director Africa,

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
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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
Catherine Condon, MPA, AOD Administrator

Lead CPU Analyst: Michael Ulibarri **Assisting CPU Analyst(s):** Mike Bivians LaMonte Love Joel Case	**Date of Review:** 5/2/2019 **Date of DMC-ODS Implementation:** 4/1/2017
County: Marin County	**County Address:** 20 North San Pedro Road, Room 2021 San Rafael, CA 94903-4158
County Contact Name/Title: Jei Africa / Director Catherine Condon / Administrator	**County Phone Number/Email:** (415) 473-7595 / JAfrica@marincounty.net (415) 473-4218 / Ccondon@marincounty.org
Report Prepared by: Michael Ulibarri	**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 via teleconference on 05/21/2019. The following individuals were present:

- Representing DHCS:
  Michael Ulibarri, Assistant Governmental Program Analyst (AGPA)
  Mike Bivians, AGPA
  LaMonte Love, AGPA
  Joel Case, AGPA
  Cynthia Hudgins, Staff Services Manager II

- Representing Marin County:
  Jei Africa, CATC-V, Director
  Catherine Condon, AOD Administrator
  David Rothery, Compliance Officer

During the Entrance Conference the following topics were discussed:

- Introductions of both the DHCS and Marin County representatives present at the meeting.
- An overview of how the review would be conducted was provided by DHCS.
- Preliminary questions and concerns.

Exit Conference:
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- Representing DHCS:
  Michael Ulibarri, AGPA
  Mike Bivians, AGPA
  LaMonte Love, AGPA
  Joel Case, AGPA
  Cynthia Hudgins, SSMII

- Representing Marin County:
  Jei Africa, CATC-V, Director
  Catherine Condon, AOD Administrator
  David Rothery, Compliance Officer

During the Exit Conference, the following topics were discussed:

- A review of the county's tentative deficiencies was presented by DHCS.
- Follow-up on a list of items needing further research by DHCS.

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

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

2.0 MEMBER SERVICES

The following deficiency in the member services requirements were identified:

COMPLIANCE DEFICIENCY:

CD 2.16:

Intergovernmental Agreement Exhibit A, Attachment I, III, F, 3, x.

x. Have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services and make oral interpretation services available for beneficiaries, as needed.

Finding: As an evaluation of the effectiveness of the access line, DHCS conducted a total of four test calls to the line on the following dates and times:

04/09/2019 at 10:43 a.m.
04/09/2019 at 10:45 a.m.
04/10/2019 at 7:36 a.m.
04/10/2019 at 1:00pm

The Plan's Beneficiary Access Line did not meet the 24/7 requirement. Two calls made on 04/09/2019 resulted in neither call answered by a live person. DHCS left a message at 10:45 requesting a call back for more information on how to receive DMC-ODS services. The access line representative returned the call 3 hours and 21 minutes later at 2:06 p.m. and left a voice message that we could call back and leave another message on their secure voice mail if we still needed information.

The call placed on 4/10/2019 at 7:36 a.m., started with a recording and was answered by a live representative 6 minutes after the call was placed. The access line representative asked DHCS to call back between 8:00 a.m. and 5:00 p.m. because the information they were able to provide was limited.

The call placed on 4/10/2019 at 1:00 p.m., resulted in a successful connection to a clinician who attempted a screening and provided information on how a beneficiary might receive information and access to care.

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.

Findings: The Plan's policy does not include that the following items are verified through a primary source:

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

The Plan's policy does not include that the following items may be verified through a non-primary source:

- Work history
- Hospital and clinic privileges in good standing
- History of any suspension
- Current Drug Enforcement Administration identification number
- National Provider Identifier number
- Current malpractice insurance…
- History of liability claims against the provider
- Provider information, if any, entered in the National Practitioner Data Bank
- History of sanctions
- Suspended and Ineligible Provider List …
- History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards

The Plan's policy and procedure does not address that the Plan verifies and documents at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials.

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 does not require network providers who deliver covered services to sign a written attestation regarding their credentials.

5.0 COORDINATION OF CARE

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

COMPLIANCE DEFICIENCY:

CD 5.33:

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

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

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

Finding: The Plan's submitted coordination of care policy and procedure does not include the following:

- The beneficiary provided information on how to contact the designated person
- The coordination of the services the contractor furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization.
- The coordination of the services the contractor furnishes to the beneficiary with the services the beneficiary receives in fee for service (FFS) Medicaid.

- The coordination of the services the contractor furnishes to the beneficiary with the services the beneficiary receives from community and social support providers.
- Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.
- Share with the Department or other managed care organizations serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.
- Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.
- Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, and 42 CFR Part 2, to the extent that they are applicable.

6.0 GRIEVANCE, APPEAL, AND FAIR HEARING

The following deficiency in grievance, appeal, and fair hearing regulations, standards, or protocol requirements were 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 submitted grievance and appeals procedure does not address the following timeliness requirements:

If extension is granted:

- Plan provides beneficiary with written notice for reason of extension within two (2) days
- Plan shall resolve the appeal as expeditiously as the appellant's health condition requires and no later than the date the extension expires.

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 requirement:

- Frequency of follow-up appointments in accordance with individualized treatment plans

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 is non-compliant:

- Open Admissions Report

8.0 PROGRAM INTEGRITY

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

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

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 provided a draft copy of the written procedure for the prompt reporting of all overpayments identified or recovered to DHCS, therefore the State could not validate compliance.