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

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

August 13, 2020

Sent via e-mail to: tvartan@sjcbhs.org

Tony Vartan, LCSW, Behavioral Health Director
San Joaquin County Behavioral Health Services
1212 N. California Street
Stockton, CA 95202

SUBJECT: Annual County Compliance Report

Dear Director Vartan:

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 San Joaquin 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 San Joaquin 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.

San Joaquin 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 9/14/2020. Please use enclosed CAP plan form when completing the CAP. CAP and supporting documentation to be e-mailed to the CMU analyst at MCBHDMonitoring@dhcs.ca.gov.

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

Sincerely,

Emanuel Hernandez

Emanuel Hernandez
(916) 713-8667
emanuel.hernandez@dhcs.ca.gov

Audits and Investigations Division
Medical Review Branch
Behavioral Health Compliance Section
County Compliance Unit
1500 Capitol Ave., MS 2305
Sacramento, CA 95814
http://www.dhcs.ca.gov

Distribution:

To: Director Vartan,

CC: Mateo Hernandez, Audits and Investigations, Medical Review Branch Acting Chief
Lanette Castleman, Audits and Investigations, Behavioral Health Compliance Section Chief
Mayumi Hata, Audits and Investigations, County Compliance Unit Chief
Michael Bivians, Audits and Investigations, County Compliance Monitoring II Chief
Janet Rudnick, Audits and Investigations, Provider Compliance Unit Chief
Kamilah Holloway, Medi-Cal Behavioral Health Division, Plan and Network Monitoring Branch Chief
MCBHDMonitoring@dhcs.ca.gov, County and Provider Monitoring Unit
Frances Hutchins, San Joaquin Behavioral Health Services Assistant Director,
Donna Bickham, San Joaquin County Behavioral Health Services Deputy Director

Lead CCU Analyst: Emanuel Hernandez **Assisting CCU Analyst(s):** None	**Date of Review:** June 2020 **Date of DMC-ODS Implementation:** 06/29/2018
County: San Joaquin County	**County Address:** 1212 N. California Street, Stockton, CA 95202
County Contact Name/Title: Donna Bickham	**County Phone Number/Email:** (209) 468-8442 dbickham@sjcbhs.org
Report Prepared by: Emanuel Hernandez	**Report Approved by:** Mayumi Hata

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	2
2.0 Member Services	0
3.0 Service Provisions	0
4.0 Access	0
5.0 Coordination of Care	0
6.0 Monitoring	4
7.0 Program Integrity	2
8.0 Compliance	0

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.

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 1.6:
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

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

Finding: The Plan's attestation does not contain the following requirements:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy.

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.

Finding: The Plan's Credentialing policy does not require the following elements are verified, and documented for each network provider:

- 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.

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.

Finding: The Plan did not provide a beneficiary handbook using the DHCS developed model. The Plan's handbook did not include how to access auxiliary aids and services, including additional information in alternative formats or languages. The Plan's beneficiary handbook was not placed in a location on the county's website that is prominent and readily accessible. The beneficiary handbook is listed under a drop down tab identified as the "Drug/Medi-Cal Organized Delivery System Waiver." Beneficiaries are not likely to understand what that means.

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.

Finding: The Plan did not provide a provider directory containing the required elements. The following elements were missing:

- The provider's name as well as any group affiliation.
- Street address(s).
- National Provider Identifier number.

CD 6.26

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
         SUD - Program, Policy and Fiscal Division
         Performance & Integrity Branch
         PO Box 997413, MS-2627
         Sacramento, CA 95899-7413

Finding: The Plan indicated a total of nine (9) DMC-ODS monitoring reports were sent to DHCS for SFY 2018-19. The Plan did not monitor all providers for DMC-ODS programmatic and fiscal requirements. The Plan did monitor nine (9) of sixteen (16) Plan and sub-contracted providers for DMC-ODS programmatic and/or fiscal requirements. The Plan did submit seven (7) of nine (9) DMC-ODS programmatic and fiscal monitoring reports secure and encrypted. The Plan did submit nine (9) of nine (9) DMC-ODS programmatic and fiscal monitoring reports to DHCS within two weeks of report issuance.

CD 6.29

Intergovernmental Agreement Exhibit A, Attachment I, III, AA, 3, iii

3. The Contractor shall include the following provider requirements in all subcontracts with providers:
    iii. Evidence Based Practices (EBPs): Providers will implement at least two of the following EBPs based on the timeline established in the county implementation plan. The two EBPs are per provider per service modality. Counties will ensure the providers have implemented EBPs.
        a. Motivational Interviewing
        b. Cognitive-Behavioral Therapy
        c. Relapse Prevention
        d. Trauma-Informed Treatment
        e. Psycho-Education

Finding: The Plan does not ensure that providers have monitored implementation and utilization of Evidence Based Practices of the Plan's network providers.

7.0 PROGRAM INTEGRITY

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.

Finding: The Plan does not ensure overpayments are properly communicated to DHCS.

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.

Finding: The Plan did not ensure that San Joaquin County Behavioral Health SUD program Medical Director has a valid signed Code of Conduct. The document attachment for Dr. Hart is signed with a date of 07/01/2020, however the Director signature is dated 02/22/2010.

The San Joaquin County Director's signed Code of Conduct for Aegis Medical Director Brian Talluer, 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.
- Conflict of interest.
- Providing services beyond scope.
- Discrimination against beneficiaries or staff.
- Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff.
- Protection of beneficiary confidentiality.
- Cooperate with complaint investigations.
- Shall be clearly documented, signed and dated by a provider representative and the physician.

TECHNICAL ASSISTANCE

San Joaquin County did not request any technical assistance for SFY 2019-20.