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

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*ACTING DIRECTOR*

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January 28, 2020

Sent via e-mail to: cboyden@smcgov.org

Clara Boyden, Deputy Director, Alcohol and Other Drug Services
San Mateo County Behavioral Health and Recovery Services
310 Harbor Blvd., Building E
Belmont, CA 94002

SUBJECT: Annual County Compliance Unit Report

Dear Deputy Director Boyden:

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 Mateo 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 Mateo 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 Mateo 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 2/28/2020. 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,

Jessica Jenkins
(916) 713-8577
jessica.jenkins@dhcs.ca.gov

Distribution:

To: Deputy Director Boyden,

CC: Kelly Molohan, Audit and Investigation, Medical Review Branch Chief
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MCBHDMonitoring@dhcs.ca.gov, County and Provider Monitoring Unit
Diana Hill, San Mateo County Health Services Manager I

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|---|---|
| **Lead CCU Analyst:**<br>Jessica Jenkins | **Date of Review:**<br>January 2020 |
| **County:**<br>San Mateo | **County Address:**<br>310 Harbor Blvd., Building E<br>Belmont, CA 94002 |
| **County Contact Name/Title:**<br>Clara Boyden/SUD Administrator | **County Phone Number/Email:**<br>650-802-5101<br>cboyden@smcgov.org |
| **Report Prepared by:**<br>Jessica Jenkins | **Report Approved by:**<br>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 | 4 |
| 2.0 Member Services | 0 |
| 3.0 Service Provisions | 0 |
| 4.0 Access | 0 |
| 5.0 Coordination of Care | 0 |
| 6.0 Monitoring | 2 |
| 7.0 Program Integrity | 4 |
| 8.0 Compliance | 8 |

## CORRECTIVE ACTION PLAN (CAP)

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

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

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

The CMU liaison will monitor progress of the CAP completion.

## 1.0 ADMINISTRATION

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

COMPLIANCE DEFICIENCIES:

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

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

**Finding**: The Plan does not ensure SUD program professional staff have 5 hours of continuing education units in addiction medicine annually.

**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 did not provide signed copies of credentialing attestations from three (3) of the Plan's network providers.

**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 did not provide evidence of a documented process for the credentialing and re-credentialing of network providers.

**CD 1.9:**

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 3, i-iii

i. The Contractor shall comply with the care and coordination requirements of this section.
ii. As all beneficiaries receiving DMC-ODS services have special health care needs, the Contractor shall implement mechanisms for identifying, assessing, and producing a treatment plan for all beneficiaries that have been assessed to need a course of treatment, and as specified below.
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; and
        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.

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 3, v, b

b. Developed by a person trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR §441.301(c)(1) and (2).

Intergovernmental Agreement Exhibit A, Attachment I, III, G, 1

1. In addition to meeting the coordination and continuity of care requirements the Contractor shall develop a care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care. Contractor is responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services

**Finding**: The Plan did not provide evidence that it trains network providers on care coordination procedures.

## 6.0 MONITORING

The following deficiencies in monitoring were identified:

COMPLIANCE DEFICIENCIES:

**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.

DHCS 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 does not provide a provider directory containing the required element:

- California license type and number

**CD 6.27**

Intergovernmental Agreement Exhibit A, Attachment I, III, EE, 2 & 5

2. If significant deficiencies or significant evidence of noncompliance with the terms of the DMC-ODS waiver, or this Agreement, are found in a county, DHCS shall engage the Contractor to determine if there are challenges that can be addressed with facilitation and technical assistance. If the Contractor remains noncompliant, the Contractor shall submit a CAP to DHCS. The CAP shall detail how and when the Contractor shall remedy the issue(s). DHCS may remove the Contractor from participating in the Waiver if the CAP is not promptly implemented.

5. The Contractor shall monitor and attest compliance and/or completion by providers with CAP requirements (detailed in Article III.DD) of this Exhibit as required by any PSPP review. The Contractor shall attest to DHCS, using the form developed by DHCS that the requirements in the CAP have been completed by the Contractor and/or the provider. Submission of DHCS Form 8049 by Contractor shall be accomplished within the timeline specified in the approved CAP, as noticed by DHCS.

**Finding:** Plan did not submit Form 8049 attesting to compliance with CAPs by network providers regarding DMCM Post Service Pre Payment.

## 7.0 PROGRAM INTEGRITY

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

COMPLIANCE DEFICIENCIES:

**CD 7.41:**
Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, ii, b & g

ii. The arrangements or procedures shall include the following:
   a. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.
   g. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the Department Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

**Finding**: The Plan does not ensure prompt reporting of all overpayments to DHCS.

**CD 7.42:**
Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, v, b

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

**Finding**: The Plan does not ensure network providers properly report overpayments made by the Plan.

**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.

MHSUD 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 7.46:**

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

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

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

i. The CalOMS-Tx business rules and requirements are:
   c. Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.
   d. Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements.
   e. Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider no activity" report records in an electronic format approved by DHCS.
   f. Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified in (Document 3S) for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

**Finding**: The following CalOMS Tx reports are non-compliant:

- Open Admissions Report
- Open Providers Report

## 8.0 COMPLIANCE

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

COMPLIANCE DEFICIENCIES:

**CD 8.50**
Intergovernmental Agreement Exhibit A, Attachment I, III, Y, 8, ii, v, a

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

**Finding:** The Plan has not resolved previous deficiencies identified by DHCS in SFY 2018-19 CD #1.2

**CD 8.51**
Intergovernmental Agreement Exhibit A, Attachment I, III, Y, 8, ii, v, a

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

**Finding:** The Plan has not resolved previous deficiencies identified by DHCS in SFY 2018-19 CD #2.10

**CD 8.52**
Intergovernmental Agreement Exhibit A, Attachment I, III, Y, 8, ii, v, a

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

**Finding:** The Plan has not resolved previous deficiencies identified by DHCS in SFY 2018-19 CD #4.26

**CD 8.53**
Intergovernmental Agreement Exhibit A, Attachment I, III, Y, 8, ii, v, a

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

**Finding:** The Plan has not resolved previous deficiencies identified by DHCS in SFY 2018-19 CD #4.27

**CD 8.54**
Intergovernmental Agreement Exhibit A, Attachment I, III, Y, 8, ii, v, a

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

**Finding:** The Plan has not resolved previous deficiencies identified by DHCS in SFY 2018-19 CD #7.46

**CD 8.55**
Intergovernmental Agreement Exhibit A, Attachment I, III, Y, 8, ii, v, a

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

**Finding:** The Plan has not resolved previous deficiencies identified by DHCS in SFY 2018-19 CD #7.50

**CD 8.56**
Intergovernmental Agreement Exhibit A, Attachment I, III, Y, 8, ii, v, a

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

**Finding:** The Plan has not resolved previous deficiencies identified by DHCS in SFY 2018-19 CD #8.58

**CD 8.57**

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

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

**Finding:** The Plan has not resolved previous deficiencies identified by DHCS in SFY 2018-19 CD #8.64

## TECHNICAL ASSISTANCE

DHCS's County Compliance Analyst will make referrals to the DHCS County Monitoring Liaison for the training and/or technical assistance areas identified below:

**CalOMS:** The Plan would like TA on resolving Open Admissions and Provider Not Reporting errors.