State of California—Health and Human Services Agency

Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

May 10, 2019

Sent via e-mail to: bruce.copley@hhs.sccgov.org

Bruce Copley, Director
Santa Clara County Department of Alcohol and Drug Services
976 Lenzen Avenue, 3rd Floor
San Jose, CA 95126-8703

SUBJECT: Annual County Performance Unit Report

Dear Director Copley:

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

Santa Clara County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 6/10/2019. 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 Copley

CC: Tracie Walker, Performance & Integrity Branch Chief
Sandi Snelgrove, Policy and Prevention 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
Leilani Villanueva, Senior Health Care Program Administrator

Lead CPU Analyst: Jamari Robinson **Assisting CPU Analyst(s):** Michael Ulibarri Mike Bivians	**Date of Review:** 3/26/2019 **-** 3/27/2019
County: Santa Clara County	**County Address:** 976 Lenzen Avenue 3rd Floor San Jose, CA 95126
County Contact Name/Title: Bruce Copley	**County Phone Number/Email:** 408-792-5691 bruce.copley@hhs.sccgov.org
Report Prepared by: Mike Bivians Jamari Robinson	**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 976 Lenzen Avenue 3rd Floor on 3/26/2019. The following individuals were present:

- Representing DHCS:
  Jamari Robinson, Associate Governmental Program Analyst (AGPA)
  Michael Ulibarri, AGPA
  Michael Bivians, AGPA
  Cynthia Hudgins, Quality Monitoring Section Chief

- Representing Santa Clara County:
  Bruce Copley, Director
  Leilani Villanueva, Senior Health Care Program Administrator
  Noel Panlilio, Senior Health Care Program Manager
  Kakoli Banerjee, Director Research & Outcome Measurement
  Tammy Ramsey, Senior Health Care Program Administrator
  Sue Nelson, Division Director, Children, Family and Community Services
  Steve Lowensbery, Clinical Standards Coordinator
  Domingo Acevedo, Senior Health Care Program Manager
  Tianna Nelson, Division Director, Quality Improvement
  Martha Martinez, Senior Health Care Program Administrator
  Mira Parwiz, Division Director, Medication and Addiction Treatment
  Summer Imamura, Compliance Analyst

During the Entrance Conference the following topics were discussed:

- Introductions
- Overview of Monitoring Purpose and Process
- County System of Service Overview

Exit Conference:
An exit conference was conducted at 976 Lenzen Avenue 3rd Floor on 3/27/2019. The following individuals were present:

- Representing DHCS:
  Jamari Robinson, AGPA
  Michael Ulibarri, AGPA
  Michael Bivians, AGPA

- Representing Santa Clara County:
  Bruce Copley, Director
  Leilani Villanueva, Sr. HCPA
  Noel Panlilio, Sr. HCPM
  Kakoli Banerjee, Dir. ROM
  Tammy Ramsey, Sr. HCPA
  Steve Lowensbery, CSC
  Domingo Acevedo, Sr. HCPM
  Martha Martinez, Sr. HCPA
  Mira Parwiz, Div. Dir., MAT
  Summer Imamura, CA

During the Exit Conference the following topics were discussed:
- Technical Assistance regarding specific questions on the monitoring tool.
- Reviewed all follow-up items for both the County and DHCS.
- Final review of compliance deficiencies and recommendations.

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	**1**
2.0 SABG Monitoring	**2**
3.0 Perinatal	**0**
4.0 Adolescent/Youth Treatment	**0**
5.0 Primary Prevention	**0**
6.0 Cultural Competence	**2**
7.0 CalOMS and DATAR	**1**
8.0 Privacy and Information Security	**4**

PREVIOUS CAPs

During the SFY 2018-19 review, the following CAP with CDs were discussed and are still outstanding.

2017-18:

CD 7.41b:
Finding: The County and its providers did not submit annual updates or client discharges for beneficiaries in treatment longer than twelve months during Fiscal Year 17/18.
Reason for non-clearance of CD: County stated they completely addressed the deficiency and no further action was required on their part.
County plan to remediate: During the DHCS visit in June 2018, the County notified DHCS that there were issues with the State database migration that was preventing the County from submitting annual updates. The County states they have been working with DHCS to resolve issues with beneficiaries that have original admission dates older than 2005.
Original expected date of completion: 9-21-18
Updated/ revised date of completion: 9-30-19

CD 8.60:
Finding: The County did not provide policies, procedures, or practices in place that govern the usage of Electronic Health Records (EHRs).
Reason for non-clearance of CD: The County stated this document was created, and submitted as a draft to County Council. As of the date of this review, the document is still with County Council.
County plan to remediate: The County will work with County Council to get approval by June 30, 2019.
Original expected date of completion: 11-30-18
Updated/ revised date of completion: 6-30-19

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 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 subcontractor staff compliance with the Hatch Act.

2.0 SABG MONITORING

The following deficiencies in the SABG monitoring requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 2.11

SABG State-County Contract Exhibit A, Attachment 1 A1, Part 1, Section 1, C, 1

Performance under the terms of this Exhibit A, Attachment I, Part I, is subject to all applicable federal and state laws, regulations, and standards. In accepting DHCS drug and alcohol SABG allocation pursuant to HSC Sections 11814(a) and (b), Contractor shall:

(i) establish, and shall require its subcontractors to establish, written policies and procedures consistent with the control requirements set forth below;

(ii) monitor for compliance with the written procedures; and (iii) be accountable for audit exceptions taken by DHCS against the Contractor and its subcontractors for any failure to comply with these requirements:

a. HSC, Division 10.5, Part 2 commencing with Section 11760.
b. Title 9, California Code of Regulations (CCR) (herein referred to as Title 9), Division 4, commencing with Section 9000.
c. Government Code, Title 2, Division 4, Part 2, Chapter 2, Article 1.7.
d. Government Code, Article 7, Federally Mandated Audits of Block Grant Funds Allocated to Local Agencies, Chapter 1, Part 1, Division 2, Title 5, commencing at Section 53130.
e. Title 42 United State Code (USC), Sections 300x-21 through 300x-31, 300x-34, 300x-53, 300x-57, and 330x-64 through 66.
f. Title 2, CFR 200 -The Uniform Administration Requirements, Cost Principles and Audit Requirements for Federal Awards.
g. Title 45, Code of Federal Regulations (CFR), Sections 96.30 through 96.33 and Sections 96.120 through 96.137.
h. Title 42, CFR, Sections 8.1 through 8.6.
i. Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, Subparts A – E).
j. Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances.
k. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures). Contractor shall be familiar with the above laws, regulations, and guidelines and shall assure that its subcontractors are also familiar with such requirements.

Finding: The County did not provide evidence of written policies and procedures that outline the steps taken to monitor County-run SABG Tx programs.

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 submitted only 7 out of a total of 14 SABG monitoring reports for SFY 17-18 to DHCS within two weeks of report issuance. The remaining 7 monitoring reports were submitted between 5 and 12 weeks of report issuance.

6.0 CULTURAL COMPETENCE

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

COMPLIANCE DEFICIENCIES:

CD 6.27:

SABG State-County Contract, Exhibit A, Attachment I AI, Part II, J
Cultural and Linguistic Proficiency.
To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Contract shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V).

Office of Minority Health National Culturally and Linguistically Appropriate Services (CLAS) Standards, Standard 6, Standard 13
Standard 6 - Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
Standard 13 - Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

Finding: The County did not provide evidence of compliance for the following CLAS Standards:
- Standard 6
- Standard 13

CD 6.29:

SABG State-County Contract, Exhibit A, Attachment I AI, Part II, J
Cultural and Linguistic Proficiency.
To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Contract shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V)

Office of Minority Health National Culturally and Linguistically Appropriate Services (CLAS) Standards, Standard 15
Standard 15 - Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

Finding: The County did not demonstrate communication efforts to inform County stakeholders and the general public of CLAS implementation.

7.0 CALIFORNIA OUTCOMES MEASUREMENT SYSTEM TREATMENT (CalOMS Tx) AND DRUG AND ALCOHOL TREATMENT ACCESS REPORT (DATAR)

The following deficiency in CalOMS and DATAR regulations, standards, or protocol requirements was identified:

COMPLIANCE DEFICIENCY:

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.

8.0 PRIVACY AND INFORMATION SECURITY

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

COMPLIANCE DEFICIENCIES:

CD 8.35:

SABG State-County Contract, Exhibit F, F-1, 3, C, 2
Contractor shall not directly or indirectly receive remuneration in exchange for Department PHI.

SABG State-County Contract, Exhibit F, F-2, 3, B, 1-2
Contractor agrees:
1) *Nondisclosure. Not to use or disclose Department PI or PII other than as permitted or required by this Agreement or as required by applicable state and Federal law.*

2) *Safeguards. To implement appropriate and reasonable administrative, technical, and physical safeguards to protect the security, confidentiality and integrity of Department PI and PII, to protect against anticipated threats or hazards to the security or integrity of Department PI and PII, and to prevent use or disclosure of Department PI or PII other than as provided for by this Agreement…*

Finding: The County did not demonstrate appropriate safeguards were in place preventing staff from receiving remuneration in exchange for PHI.

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 8.40:

SABG State-County Contract, Exhibit F, F-1, 3, D, 2

… Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR Section 164, subpart C, in compliance with 45 CFR Section 164.316. Contractor shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Contractor will provide the Department with its current and updated policies upon request.

Finding: The County did not provide evidence of policies, procedures, and practices that govern the usage of Electronic Health Records (EHRs).

CD 8.41:

ADP Bulletin 10-01

2. *Counties maintain an Electronic Signature Agreement (Exhibit 1) for the terms of use of an electronic signature signed by both the individual requesting electronic signature authorization and the County Alcohol and Drug Program Administrator or his/her designee.*
3. *County Alcohol and Drug Program Administrators complete a County Alcohol and Drug Program Administrator's Electronic Signature Certification form (Exhibit 2), certifying that electronic systems used by the county's alcohol and drug operations, including contract provider systems, meet the standards..*

Finding: The County does not maintain signed Electronic Signature Agreements for each electronic signature used and did not provide a County Alcohol and Drug Program Administrator's Electronic Signature Certification form.

9.0 TECHNICAL ASSISTANCE

The County did not make any request for technical assistance during this FY site review.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

May 10, 2019

Sent via e-mail to: <bruce.copley@hhs.sccgov.org>

Bruce Copley, Director
Santa Clara County Department of Alcohol and Drug Services
976 Lenzen Avenue, 3rd Floor
San Jose, CA 95126-8703

SUBJECT: Annual County Performance Unit Report

Dear Director Copley:

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

Santa Clara County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 6/10/2019. 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 Ulibarri

Michael Ulibarri
(916) 713-8967
michael.ulibarri@dhcs.ca.gov

Distribution:

To: Director Copley

CC: Tracie Walker, Performance & Integrity Branch Chief
Sandi Snelgrove, Policy and Prevention 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 Supervisor
Leilani Villanueva, Senior Health Care Program Administrator
Tammy Ramsey, Senior Health Care Program Administrator

Lead CPU Analyst: Jamari Robinson **Assisting CPU Analyst(s):** Michael Ulibarri Michael Bivians	**Date of Review:** 3/26/2019 **-** 3/27/2019 **Implementation Date:** 06/15/2017
County: Santa Clara County	**County Address:** 976 Lenzen Avenue 3rd Floor San Jose, CA 95126
County Contact Name/Title: Bruce Copley	**County Phone Number/Email:** 408-792-5691 bruce.copley@hhs.sccgov.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 at 976 Lenzen Avenue 3rd Floor, San Jose, CA 95126 on 3/26/2019. The following individuals were present:

- Representing DHCS:
  Jamari Robinson, Associate Governmental Program Analyst (AGPA)
  Michael Ulibarri, AGPA
  Michael Bivians, AGPA
  Cynthia Hudgins, Quality Monitoring Section Chief

- Representing Santa Clara County:
  Bruce Copley, Director
  Leilani Villanueva, Senior Health Care Program Administrator
  Noel Panlilio, Senior Health Care Program Manager
  Kakoli Banerjee, Director Research & Outcome Measurement
  Tammy Ramsey, Senior Health Care Program Administrator
  Sue Nelson, Division Director, Children, Family and Community Services
  Steve Lowensbery, Clinical Standards Coordinator
  Domingo Acevedo, Senior Health Care Program Manager
  Tianna Nelson, Division Director, Quality Improvement
  Martha Martinez, Senior Health Care Program Administrator
  Mira Parwiz, Division Director, Medication and Addiction Treatment
  Summer Imamura, Compliance Analyst

During the Entrance Conference the following topics were discussed:
  Introductions
  Overview of Monitoring Purpose and Process
  County System of Service Overview

Exit Conference:
An exit conference was conducted at 976 Lenzen Avenue 3rd Floor, San Jose, CA 95126 on 3/27/2019. The following individuals were present:

- Representing DHCS:
  Jamari Robinson, AGPA
  Michael Ulibarri, AGPA
  Michael Bivians, AGPA

- Representing Santa Clara County:
  Bruce Copley, Director
  Leilani Villanueva, Sr. HCPA
  Noel Panlilio, Sr. HCPM
  Kakoli Banerjee, Dir. ROM

Tammy Ramsey, Sr. HCPA
Steve Lowensbery, CSC
Domingo Acevedo, Sr. HCPM
Martha Martinez, Sr. HCPA
Mira Parwiz, Div. Dir., MAT
Summer Imamura, CA

During the Exit Conference the following topics were discussed:

Follow-up items for both the County and DHCS.
All compliance deficiencies and recommendations.
DHCS outlined the next steps and when the County should expect their final report.

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD) AND NEW REQUIREMENTS (NR)

Section:	Number of CD's and NR's:
1.0 Administration	**0**
2.0 Member Services	**1**
3.0 Service Provisions	**1**
4.0 Access	**2**
5.0 Continuity and Coordination of Care	**2**
6.0 Grievance, Appeal, and Fair Hearing Process	**1**
7.0 Quality	**2**
8.0 Program Integrity	**5**

PREVIOUS CAPs

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

2017-2018:

CD 1.10:
Finding: The Plan does not require county and subcontracted providers to be trained prior to delivering services.
CD 4.27:
Finding: The Plan did not provide written policies and procedures on the selection and retention of network providers.
CD 4.28:
Finding: The Plan did not provide written policies and procedures for credentialing and re-credentialing network providers.
CD 4.29:
Finding: The Plan does not have a single case agreement process to ensure that NTP beneficiaries are able to receive their dosing while they are away from their provider.

> **Reason for non-clearance of above CDs:** Due to a recent departmental integration of the county's substance use disorders and mental health divisions, the county faced internal delays when determining whether to create Mental Health/SUD specific policies and procedures or integrated policies and procedures. With the delay, evidence of compliance with the requirement could not be provided.
> **County plan to remediate**: County agreed to have the above referenced policies and procedures implemented 06/30/2019.
> **Original expected date of completion:** 11/30/2018.
> **Updated/ revised date of completion**: 06/30/2019.

CD 5.37:
Finding: The Plan has not submitted the required two executed Memorandums of Understanding with the Medi-Cal managed care plan(s) within the county.
Reason for non-clearance of CD: There was delay in agreement to terms between the health plans and the Santa Clara County, County -Counsel.
County plan to remediate: County is actively working internally and with health plans to complete the MOU process. County states the MOUs are with the health plans for final signature as of the date of this report. County agreed to submit the two required executed MOUs by 06/30/2019.
Original expected date of completion: 6/15/17 (DMC-ODS implementation date), CAP date: 11/30/2018.
New expected date of completion: 06/30/2019.

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 deficiency in the member services requirements was 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: The Plan does not have an effective 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services.

The State conducted a test of the 24/7 toll free access line on 03/06/2019 and 04/04/2019. Below are the results of the test.

03/06/2019 11:00 a.m.:
Call was answered by recording and prompt instructed caller to select language choice. After selecting language, prompt advised caller that if there was a life-threatening emergency to hang up and call 9-1-1. Next instructions from prompt were to enter medical record ID number. If medical record ID was unavailable or unknown, instructions were to stay on the line. At this point the call was dropped / line went dead when transferred.

03/06/2019 11:02 a.m.:
Call was answered by recording and prompt instructed caller to select language choice. After selecting language, prompt advised caller that if there was a life-threatening emergency to hang up and call 9-1-1. Next instructions from prompt were to enter medical record ID number. If medical record ID was unavailable or unknown, instructions were to stay on the line. At this point the call was dropped / line went silent when transferred.

03/06/2019 11:05 a.m.:
Call was answered by recording and prompt instructed caller to select language choice. After selecting language, prompt advised caller that if there was a life-threatening emergency to hang up and call 9-1-1. Next instructions from prompt were to enter medical record ID number. If medical record ID was unavailable or unknown, instructions were to stay on the line. Call was transferred and picked up. Sounds could be heard in the background but no live operator answered the call.

03/06/2019 11:07 a.m.
Call was answered by recording and prompt instructed caller to select language choice. After selecting language, prompt advised caller that if there was a life-threatening emergency to hang up and dial 9-1-1. Next instructions from prompt were to enter medical record ID number. If medical record ID was unavailable or unknown, instructions were to stay on the line. Call was transferred and picked up. Sounds could be heard in the background but no live operator answered the call.

04/04/2019 7:35 a.m.:
A recording prompt offered the option to be transferred to Horizons South for men's detox services. The answering operator informed caller that no screening or assessments were made by Horizons South and recommended that we wait 25 minutes to call Gateway when they opened at 8: .m.

04/30/2019 9:24 a.m.
Call was answered by recording and prompt instructed caller to select language choice. After selecting language, prompt advised caller that if there was a life-threatening emergency to hang up and call 9-1-1. Next instructions from prompt were to enter medical record ID number. If medical record ID was unavailable or unknown, instructions were to stay on the line. When transferred, a recording stated that they were experiencing difficulties and to please call back at another time.

04/30/2019 9:24 a.m.
Call was answered by recording and prompt instructed caller to select language choice. After selecting language, prompt advised caller that if there was a life-threatening emergency to hang up and call 9-1-1. Next instructions from prompt were to enter medical record ID number. If medical record ID was unavailable or unknown, instructions were to stay on the line. At this point the call was dropped / line went silent when transferred.

3.0 SERVICE PROVISION

The following deficiency in service provision requirements was identified:

COMPLIANCE DEFICIENCIES:

CD 3.17:

Intergovernmental Agreement Exhibit A, Attachment I, III, C, 2.

2. The Contractor shall deliver the DMC-ODS Covered Services within a continuum of care as defined in the ASAM criteria.

Intergovernmental Agreement Exhibit A, Attachment I, III, C, 3,i-ix.

3. Mandatory DMC-ODS Covered Services include:
   - i. Withdrawal Management (minimum one level);
   - ii. Intensive Outpatient;
   - iii Outpatient;
   - iv. Opioid (Narcotic) Treatment Programs;
   - v. Recovery Services;
   - vi. Case Management;
   - vii. Physician Consultation;
   - viii. Perinatal Residential Substance Abuse Services (excluding room and board);
   - ix. Non-perinatal Residential Substance Abuse Services (excluding room and board);

Intergovernmental Agreement Exhibit A, Attachment I, III, H, 1, v.

1. The Contractor shall implement residential treatment program standards that comply with the authorization of services requirements set forth in Article II.E.4. and shall:
   - v. Ensure that at least one ASAM level of Residential Treatment Services is available to beneficiaries in the first year of implementation;

Finding: The Plan does not provide the following required levels of care:

- Early Intervention 0.5 (County does not have a Memorandum of Understanding in place with any Managed Care Plans)
- Withdrawal Management level 3.7
- Withdrawal Management level 4.0

4.0 ACCESS

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

COMPLIANCE DEFICIENCIES:

CD 4.24:

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 5, a-d.

5. 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.
    b. Nondiscrimination.
        i. The Contractor's network provider selection policies and procedures, consistent with 42 CFR §438.12, shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
    c. Excluded providers.
        i. The Contractor shall not employ or subcontract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.
    d. Additional Department requirements.
        i. The Contractor shall comply with any additional requirements established by the Department.

Finding: The Plan does not have a policy and procedure in place to address selection and retention of network providers.

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's policies and procedures do not include that the following items are verified through a primary source:

- Satisfaction of any applicable continuing education requirements, as required for the particular provider type

The Plan's policies and procedures do not include that the following items may be verified through a non-primary source:

- Work history
- Hospital and clinic privileges in good standing
- Current malpractice insurance

The Plan's policies and procedures do not address the requirement that provider credentials are reviewed every three years.

5.0 COORDINATION OF CARE

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

COMPLIANCE DEFICIENCIES:

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 does not have coordination of care procedures.

CD 5.35:

Intergovernmental Agreement Exhibit A, Attachment I, III, G, 3.

3. Contractor shall enter into a Memorandum Of Understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement may be met through an amendment to the Specialty Mental Health Managed Care Plan MOU.

i. The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

a. Comprehensive substance use, physical, and mental health screening.
b. Beneficiary engagement and participation in an integrated care program as needed;
c. Shared development of care plans by the beneficiary, caregivers and all providers;
d. Collaborative treatment planning with managed care;
e. Delineation of case management responsibilities;
f. A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;
g. Availability of clinical consultation, including consultation on medications;
h. Care coordination and effective communication among providers including procedures for exchanges of medical information;
i. Navigation support for patients and caregivers; and
j. Facilitation and tracking of referrals between systems including bidirectional referral protocol.

Finding: The Plan has not entered into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS.

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:

If extension is granted:

- Resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

Beneficiary can request continuation of benefits within the following timeframes:

- Within 10 calendar days from receipt of the Notice of Appeal Resolution OR
- Intended effective date of the decision, whichever is later

7.0 QUALITY

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

COMPLIANCE DEFICIENCIES:

CD 7.43:

Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 9

9. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.

Finding: The Plan does not have a process in place to properly monitor the safety and effectiveness of medication practices for narcotic treatment programs.

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 8.58:

Intergovernmental Agreement Exhibit A, Attachment I, III. PP, 4, 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, 5, 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 requirement(s):

- Signed and dated by a county representative
- Worksite location clearly marked and noted

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 does not ensure Medical Directors for SUD treatment programs develop medical policies and standards.

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 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.

Findings:

- The Plan does not submit results of investigations to the SUDCountyReports mailbox within two (2) business days.
- The Plan did not submit any complaints investigated in SFY 17/18 to SUDCountyReports@dhcs.ca.gov.

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 submitted policy for the prompt referral of any potential fraud, waste, or abuse to the State Medicaid Fraud Control Unit was in draft form, therefore implementation could not be verified

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 does not have a written procedure that addresses the proper reporting of all overpayments identified or recovered to DHCS.