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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

07/21/2022

Sent via e-mail to: gtsai@ph.lacounty.gov

Gary Tsai, Division Director
Los Angeles County Substance Abuse Prevention and Control
1000 S. Fremont Avenue, Bld. A-9 East, 3rd Floor, Box 34
Alhambra, CA 91803

SUBJECT: Annual DMC-ODS County Compliance Unit Findings Report

Dear Director Tsai:

The Department of Health Care Services (DHCS) is responsible for monitoring compliance to the requirements of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver and the terms of the Intergovernmental Agreement operated by Los Angeles County.

The County 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 Los Angeles County's State Fiscal Year 2021-22 DMC-ODS compliance review. The report identifies deficiencies, required corrective actions, new requirements, advisory recommendations, and referrals for technical assistance.

Los Angeles County is required to submit a Corrective Action Plan (CAP) addressing each compliance deficiency (CD) noted to the Medi-Cal Behavioral Health Division (MCBHD), Plan and Network Monitoring Branch (PNMB), County/Provider Operation and Monitoring Branch (CPOMB) Analyst by 09/21/2022. Please use the enclosed CAP form and submit the completed the CAP and supporting documentation via email to the CPOMB liaison at MCBHDMonitoring@dhcs.ca.gov.

If you have any questions or need assistance, please contact me at emanuel.hernandez@dhcs.ca.gov.

Sincerely,

Emanuel Hernandez
(916) 713-8667

Audits and Investigations Division
Medical Review Branch
Behavioral Health Compliance Section
County Compliance Unit
1500 Capitol Ave., MS 2305
Sacramento, CA 95814
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Distribution:

To: Director Tsai,

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Daniel Deniz, Los Angeles County Substance Abuse Prevention and Control, Finance Services Branch Manager

COUNTY REVIEW INFORMATION

County:
Los Angeles

County Contact Name/Title:
Daniel Deniz/Substance Abuse Prevention and Control, Finance Services Branch Chief

County Address:
1000 S. Fremont Avenue, Bld. A-9 East 3rd Floor
Alhambra, CA 91803

County Phone Number/Email:
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Date of DMC-ODS Implementation:
07/01/2017

Date of Review:
04/19/2022

Lead CCU Analyst:
Emanuel Hernandez

Assisting CCU Analyst:
N/A

Report Prepared by:
Emanuel Hernandez

Report Approved by:
Ayesha Smith

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. Fiscal Year (FY) 2020-21 Intergovernmental Agreement (IA)
   b. Fiscal Year (FY) 2021-22 Intergovernmental Agreement (IA)
   c. Mental Health and Substance Use Disorders Services (MHSUDS) Information Notices
   d. Behavioral Health Information Notices (BHIN)

ENTRANCE AND EXIT CONFERENCE SUMMARIES

Entrance Conference:

An Entrance Conference was conducted via WebEx on 04/19/2022. The following individuals were present:

- Representing DHCS:
  Emanuel Hernandez, Associate Governmental Program Analyst (AGPA)
  Kathryn Sears, County Provider Operations and Monitoring (CPOM) Unit 1 Chief

- Representing Los Angeles County:
  Gary Tsai, Division Director, Substance Abuse Prevention Control (SAPC)
  Daniel Deniz, Substance Abuse Prevention and Control, Finance Services Branch Chief
  Michelle Palmer, SAPC Compliance and Reports
  Brian Hurley, SAPC Medical Director
  Michelle Gibson, SAPC Treatment Services Deputy Director
  Babatunde Yates, SAPC Financial Services Chief
  Yanira Lima, SAPC Systems of Care Chief
  Marika Medrano, SAPC Contracts and Compliance Branch Chief
  Ruth Kantorowicz, SAPC Contracts and Compliance Section Staff Analyst
  Stephanie Chen, SAPC Community and Youth Engagement Unit
  Tina Kim, SAPC Health Outcomes and Analytics Section Director
  Andrea Hurtado, SAPC Compliance and Policies
  Antonne Moore, SAPC Strategic and Network Development Branch

During the Entrance Conference, the following topics were discussed:

- Introductions
- Overview of review process
- Overview of services provided

Exit Conference:

An Exit Conference was conducted via WebEx on 04/19/202. The following individuals were present:

- Representing DHCS:
  Emanuel Hernandez, AGPA
  Kathryn Sears, CPOM Unit 1 Chief

- Representing Los Angeles County:
  Gary Tsai, SAPC Division Director
  Michelle Palmer, SAPC Compliance and Reports
  Brian Hurley, SAPC Medical Director
  Michelle Gibson, SAPC Treatment Services Deputy Director
  Babatunde Yates, SAPC Financial Services Chief
  Yanira Lima, SAPC Systems of Care Chief
  Marika Medrano, SAPC Contracts and Compliance Branch Chief
  Ruth Kantorowicz, SAPC Contracts and Compliance Section Staff Analyst
  Stephanie Chen, SAPC Community and Youth Engagement Unit
  Tina Kim, SAPC Health Outcomes and Analytics Section Director
  Andrea Hurtado, SAPC Compliance and Policies
  Antonne Moore, SAPC Strategic and Network Development Branch

During the Exit Conference, the following topics were discussed:

- Submitting follow-up evidence
- Due date for evidence submission

SUMMARY OF FY 2021-22 COMPLIANCE DEFICIENCIES (CD)

	Section:	Number of CD's
1.0	Availability of DMC-ODS Services	7
2.0	Coordination of Care	0
3.0	Quality Assurance and Performance Improvement	4
4.0	Access and Information Requirements	0
5.0	Beneficiary Rights and Protections	0
6.0	Program Integrity	0

CORRECTIVE ACTION PLAN (CAP)

Pursuant to the Intergovernmental Agreement, Exhibit A, Attachment I, Part III, Section KK, 2, i each CD identified must be addressed via a CAP. The CAP is due within sixty (60) calendar days of the date of this monitoring report.

Please provide the following within the completed FY 2021-22 CAP:

a) DHCS' CAP Template used to document process.
b) A list of action steps to be taken to correct the CD.
c) The name of the person who will be responsible for corrections and ongoing compliance.
d) Provide a specific description on how ongoing compliance is ensured
e) A date of completion for each CD.

The CPOMB liaison will monitor progress of the CAP completion.

Category 1: AVAILABILITY OF DMC-ODS SERVICES

A review of the administrative trainings, policies and procedures was conducted to ensure compliance with applicable regulations, and standards. The following deficiencies in availability of DMC-ODS services were identified:

COMPLIANCE DEFICIENCIES:

CD 1.1.3:
Intergovernmental Agreement Exhibit A, Attachment I, II, E, 1, iii, a-d

iii. The Contractor shall comply with the following timely access requirements:
   a. Meet and require its network providers to meet Department standards for timely access to care and services, taking into account the urgency of the need for services.
   b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid FFS, if the provider serves only Medicaid beneficiaries.
   c. Make services included in this Agreement available 24 hours a day, 7 days a week, when medically necessary.
   d. Establish mechanisms to ensure compliance by network providers.

Findings: The Plan did not provide evidence demonstrating all network providers' compliance with all timely access requirements. The Plan did not provide evidence of the following timely access requirements:

- Meet and require network providers to meet DHCS standards for timely access to care and services;
- Ensure network providers offer hours of operation that are no less than offered to commercial beneficiaries or Medicaid FFS if the provider serves only Medicaid beneficiaries;
- Make services available 24 hours a day, 7 days a week when medically necessary; and
- Establish mechanism to ensure compliance by network providers.

CD 1.1.4:
Intergovernmental Agreement Exhibit A, Attachment I, II, E, 1, iii, e-f

iii. The Contractor shall comply with the following timely access requirements:
   e. Monitor network providers regularly to determine compliance.
   f. Take corrective action if there is a failure to comply by a network provider.

Findings: The Plan did not provide evidence demonstrating all network providers' compliance with timely access requirements. The Plan did not provide evidence of the following timely access requirements:

- Monitor network providers to determine compliance; and
- Take corrective action if there is a failure to comply by a network provider.

CD 1.2.1:

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

i. The Contractor shall implement written policies and procedures for selection and retention of network providers and the implemented 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, 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

CREDENTIALING POLICY 2018

For all licensed, waivered, registered and/or certified providers4, the Plan must verify and document the following items through a primary source, 5 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.

Findings: The Plan did provide evidence demonstrating implemented policies and procedures for the selection and retention of network providers however, the policy and procedure is missing the following element:

- The Plan verifies and documents credentials every three (3) years.

CD 1.4.1:
Intergovernmental Agreement Exhibit A, Attachment I, III, A, 1, iii

iii. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring. Documentation of trainings, certifications and licensure shall be contained in personnel files.

Findings: The Plan did not provide evidence demonstrating the monitoring of personnel files to ensure non-professional and professional staff employed by Los Angeles County have appropriate experience and necessary training at the time of hiring. The Plan did not provide evidence for:

- Two (2) professional/licensed staff hired by Los Angeles County during FY 2020-21.
- Two (2) non-professional staff hired by Los Angeles County during FY 2020-21.

CD 1.4.2:
Intergovernmental Agreement Exhibit A, Attachment I, III, A, 1, ii

ii. Non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff shall supervise non-professional staff.

Findings: The Plan did not provide evidence demonstrating non-professional staff employed by Los Angeles County receive appropriate onsite orientation and training prior to performing assigned duties. The Plan did not provide evidence for:

- Two (2) non-professional staff hired by Los Angeles County during FY 2020-21.

CD 1.4.8:
Intergovernmental Agreement Exhibit A, Attachment I, III, A, 1, iv
iv. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.

Findings: The Plan did not provide evidence demonstrating Behavioral Health Services physician received the annual five (5) hours of continuing medical education units in addiction medicine. Specifically:

- The continuing medical education submitted for calendar year 2019 for Behavioral Health physician Mark Perez, totaled only two and a half (2.5) hours.

The Plan did not provide evidence of continuing medical education demonstrating the Phoenix House physician received the annual five (5) hours of continuing medical education in addiction medicine. Specifically:

- The Plan did not provide evidence of continuing medical education for the Phoenix House physician Maged Botros for calendar year 2019.

The Plan did not provide evidence demonstrating the Cannon Human Services physician received the annual five (5) hours of continuing medical education in addiction medicine. Specifically:

- The Plan did not provide evidence of continuing medical education for the Canon Human Services physician Jessica Schneider for calendar year 2019.

- The continuing medical education submitted for calendar year 2020 for Cannon Human Services physician, totaled only three and half (3.5) hours.

CD 1.4.9:
Intergovernmental Agreement Exhibit A, Attachment I, III, A, 1, v
v. Professional staff (LPHAs) shall receive a minimum of five hours of continuing education related to addiction medicine each year.

Findings: The Plan did not provide evidence demonstrating Safe Refuge professional staff (LPHA) received the annual five (5) hours of continuing education in addiction medicine. Specifically:

- The Plan did not submit continuing education units for three (3) subcontractor LPHA staff for calendar year 2019.

The Plan did not provide evidence demonstrating the Phoenix professional staff (LPHA) received the annual five (5) hours of continuing education in addiction medicine. Specifically:

- The Plan did not submit continuing education units for three (3) subcontractor LPHA staff for calendar year 2019.
- The Plan did not submit continuing education units for three (3) subcontractor LPHA staff for calendar year 2020.

The Plan did not provide evidence demonstrating the Grandview professional staff (LPHA) received the annual five (5) hours of continuing education in addiction medicine. Specifically:

- The Plan submitted continuing education units for two (2) of three (3) subcontractor LPHA staff for calendar year 2019 and 2020.
- The Plan did not submit continuing education units for Eugene Vincent Caine for calendar year 2019.
- The Plan did not submit continuing education units for Bradley Carow for calendar year 2020.

Category 3: QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

A review of the practice guidelines, monitoring, and other quality assurance requirements was conducted to ensure compliance with applicable regulations and standards. The following deficiencies in quality assurance and performance improvement were identified:

COMPLIANCE DEFICIENCIES:

CD 3.2.3:
Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 5, i-ii

i. The SUD 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 written 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, and 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 SUD Medical Director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

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

Findings: The Plan did not provide evidence demonstrating the written roles and responsibilities for Phoenix House (provider #196919), Medical Director includes all required elements. The following required elements are missing, specifically:

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

- Ensure that provider's physicians are adequately trained to perform other physician duties; and
- The SUD Medical Director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

CD 3.2.4:
Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 6, 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, 6, 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.

Findings: The Plan did not provide evidence demonstrating the Code of Conduct for the Behavioral Health Services Medical Director includes all required elements. The following required elements are missing, specifically:

- Prohibition of social/business relationship with beneficiary's or their family members for personal gain;
- Providing services beyond scope;
- Discrimination against beneficiary's or staff;
- Verbally, physically, or sexually harassing, threatening, or abusing beneficiary's, family members or other staff; and
- Cooperate with complaint investigations.

The Plan did not provide evidence demonstrating the Code of Conduct for the Phoenix House Medical Director includes all required elements. The following required elements are missing, specifically:

- Signed and dated by the physician;
- Signed and dated by a provider representative;
- Use of drugs and/or alcohol;
- Prohibition of social/business relationship with beneficiary's or their family members for personal gain;
- Prohibition of sexual contact with beneficiaries;
- Conflict of interest;
- Providing services beyond scope;

- Discrimination against beneficiary's or staff;
- Verbally, physically, or sexually harassing, threatening, or abusing beneficiary's, family members or other staff;
- Protection beneficiary confidentiality; and
- Cooperate with complaint investigations.

The Plan did not provide evidence demonstrating the Code of Conduct for Tarzana Treatment Centers Medical Director includes all required elements. The following required elements are missing, specifically:

- Prohibition of social/business relationship with beneficiary's or their family members for personal gain;
- Prohibition of sexual contact with beneficiaries;
- Providing services beyond scope;
- Discrimination against beneficiary's or staff;
- Protection beneficiary confidentiality; and
- Cooperate with complaint investigations.

CD 3.4.1:
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.

Findings: The Plan's Open Admissions report is not in compliance.

CD 3.4.2:
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.

Findings: The Plan’s Open Provider report is not in compliance.

TECHNICAL ASSISTANCE

The County did not request technical assistance.