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

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

September 18, 2020

Sent via e-mail to: Phebe.Bell@co.nevada.ca.us

Phebe Bell, Director
Nevada County Behavioral Health
500 Crown Point Circle, Ste. 120
Grass Valley, CA 95945

SUBJECT: Annual County Compliance Report

Dear Director Bell:

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 Nevada 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 Nevada 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.

Nevada 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 10/19/2020. 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 at Emanuel.hernandez@dhcs.ca.gov.

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

Distribution:

To: Director Bell,

CC: Mateo Hernandez, Audits and Investigations, Medical Review Branch Acting Chief
Lanette Castleman, Audits and Investigations, Behavioral Health Compliance Section Chief
Michael Bivians, Audits and Investigations, County Compliance Monitoring II Chief
Janet Rudnick, Audits and Investigations, Provider Compliance Unit Chief
Mayumi Hata, Medi-Cal Behavioral Health Division, County/Provider Operations and Monitoring Branch Chief
MCBHDMonitoring@dhcs.ca.gov, County and Provider Monitoring Unit
Suzanne McMaster, LCSW, Nevada County AOD Program Manager
Yvonne Foley-Trumbo, Nevada County Quality Assurance Manager

Lead CCU Analyst: Emanuel Hernandez **Assisting CCU Analyst(s):** N/A	**Date of Review:** July 2020 **Date of DMC-ODS Implementation:** 06/28/2018
County: Nevada	**County Address:** 500 Crown Point Circle, Ste. 120 Grass Valley, Ca 95945
County Contact Name/Title: Suzanne McMaster/ AOD Program Manager	**County Phone Number/Email:** (530) 470-2418 Suzanne.mcmaster@co.nevada.ca.us
Report Prepared by: Emanuel Hernandez	**Report Approved by:** Lanette Castleman

REVIEW SCOPE

I. Regulations:
   a. Special Terms and Conditions (STCs) for California's Medi-Cal 2020 section 1115(a) Medicaid Demonstration STC, Part X: Drug Medi-Cal Organized Delivery System
   b. Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 438; section 438.1 through 438.930: Managed Care

II. Program Requirements:
   a. State Fiscal Year (SFY) 2019-20 Intergovernmental Agreement (IA)
   b. Mental Health and Substance Use Disorders Services (MHSUDS) Information Notices

SUMMARY OF SFY 2019-20 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	2
2.0 Member Services	0
3.0 Service Provisions	0
4.0 Access	0
5.0 Coordination of Care	0
6.0 Monitoring	3
7.0 Program Integrity	3
8.0 Compliance	0

CORRECTIVE ACTION PLAN

Pursuant to the Intergovernmental Agreement, Exhibit A, Attachment I, Part II, Section EE, 2 each CD identified must be addressed via a CAP. The CAP is due within thirty (30) calendar days of the date of this monitoring report. 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 1.6:
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

Findings: The Plan did not provide signed copies of credentialing attestations from two (2) of three (3) Plan's network providers requested. The provided attestations for Granite Wellness did not contain the following requirements:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- The application's accuracy.

CD 1.7:

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

i. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.
ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers.

MHSUDS Information Notice: 18-019

Effective immediately, Plans must implement and maintain written policies and procedures for the initial credentialing and re-credentialing of their providers in accordance with the policy outlined in this IN…

Credentialing Policy

For all licensed, waivered, registered and/or certified providers, the Plan must verify and document the following items through a primary source, as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by the Plan unless the Plan can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board.

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

In addition, Plans must verify and document the following information from each network provider, as applicable, but need not verify this information through a primary source:

1. Work history;
2. Hospital and clinic privileges in good standing;
3. History of any suspension or curtailment of hospital and clinic privileges;
4. Current Drug Enforcement Administration identification number;
5. National Provider Identifier number;
6. Current malpractice insurance in an adequate amount, as required for the particular provider type;
7. History of liability claims against the provider;
8. Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;
9. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network. This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp; and
10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards…

Provider Re-credentialing
DHCS requires each Plan to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above. The Plan must require each provider to submit any updated information needed to complete the re-credentialing process, as well as a new signed attestation. In addition to the initial credentialing requirements, re-credentialing should include documentation that the Plan has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, beneficiary grievances, and medical record reviews.

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

- Work history.

6.0 MONITORING

The following deficiencies in monitoring were identified:

COMPLIANCE DEFICIENCIES:

CD 6.25:
Intergovernmental Agreement Exhibit A, Attachment I, III, OO, 1, i, d

1. Monitoring
   i. Contractor's performance under this Exhibit A, Attachment I, shall be monitored by DHCS annually during the term is the Agreement. Monitoring criteria shall include, but not be limited to:
      d. Contractor shall conduct annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of their monitoring and audit reports to DHCS within two weeks of issuance. Reports should be sent by secure, encrypted e-mail to:
         sudcountyreports@dhcs.ca.gov

         Alternatively, mail to:
         Department of Health Care Services
         Audits and Investigations Division
         Medical Review Branch
         Behavioral Health Compliance Section
         County Compliance Unit
         1500 Capitol Ave., MS 2305
         Sacramento, CA 95814

Findings: The County did not monitor all county and subcontracted providers for compliance with DMC-ODS programmatic and fiscal requirements. Specifically:

- For SFY 2018-2019 the County monitored three (3) of ten (10) County and subcontracted providers for DMC-ODS programmatic and fiscal requirements, and submitted reports of these monitoring reviews to DHCS.
- The County submitted two (2) of three (3) DMC-ODS programmatic and fiscal monitoring reports secure and encrypted.

CD 6.30

Intergovernmental Agreement Exhibit A, Attachment I, III, E, 1, iii, d-e

iii. The Contractor shall comply with the following timely access requirements:

d. Establish mechanisms to ensure compliance by network providers.
e. Monitor network providers regularly to determine compliance.

Findings: The Plan did not monitor to ensure network provider's compliance with timely access.

CD 6.34

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 1, v, a-b

a. The Contractor shall ensure that their health programs or activities provided through electronic and information technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. When undue financial and administrative burdens or a fundamental alteration exist, the covered entity shall provide information in a format other than an electronic format that would not result in such undue financial and administrative burdens or a fundamental alteration but would ensure, to the maximum extent possible, that individuals with disabilities receive the benefits or services of the health program or activity that are provided through electronic and information technology
b. The Contractor shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid beneficiaries with physical or mental disabilities. The Contractor and its network providers shall make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless the Contractor or its network providers can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity. For the purposes of this section, the term ''reasonable modifications'' shall be interpreted in a manner consistent with the term as set forth in the ADA Title II regulation at 28 CFR 35.130(b)(7).

Findings: The Plan does not ensure that network providers are providing reasonable accommodations through electronic and information technology that are accessible to individuals with disabilities.

7.0 PROGRAM INTEGRITY

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

COMPLIANCE DEFICIENCIES:

CD 7.39:
Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, ii, a, vi

i. A compliance program that includes, at a minimum, all of the following elements:
vi. Enforcement of standards through well-publicized disciplinary guidelines.

Findings: The Plan's Compliance Program does not ensure that disciplinary guidelines are established to address fraud, waste and abuse and are well-publicized and communicated to all network providers.

CD 7.45:
Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 7, iii, a-i

iii. Written provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
a. Use of drugs and/or alcohol
b. Prohibition of social/business relationship with beneficiaries or their family members for personal gain
c. Prohibition of sexual contact with beneficiaries
d. Conflict of interest
e. Providing services beyond scope
f. Discrimination against beneficiaries or staff
g. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff
h. Protection of beneficiary confidentiality
i. Cooperate with complaint investigations

Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 7, v

v. Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a provider representative and the physician.

Findings: The Plan does not ensure that SUD program Medical Directors have a signed Code of Conduct. The Plan's SUD program Medical Director's signed Code of Conduct for Common Goals is missing the following elements:

- Use of drugs and/or alcohol.
- Prohibition of social/business relationship with beneficiaries or their family members for personal gain.
- Prohibition of sexual contact with beneficiaries.
- Conflict of interest.
- Providing services beyond scope.

- Discrimination against beneficiaries or staff.
- Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff.
- Protection of beneficiary confidentiality.
- Cooperate with complaint investigations.
- Shall be clearly documented, signed and dated by a provider representative and the physician.

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.

Findings: The following CalOMS-Tx report are non-compliant:

- Open Admissions Report.

TECHNICAL ASSISTANCE

Nevada County did not request any technical assistance for SFY 2019-20