DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
BEHAVIORAL HEALTH REVIEW BRANCH

REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF

Calaveras County Mental Health Plan

2023

Contract Number:	22-20096
Audit Period:	July 1, 2022 through June 30, 2023
Dates of Audit:	January 9, 2024 through January 19, 2024
Report Issued:	May 24, 2024

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I. INTRODUCTION

Calaveras County Behavioral Health Services (Plan) provides a variety of Specialty Mental Health Services (SMHS) for county citizens. The Plan is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of supporting the mental health needs of the community.

Calaveras County is located in northern California. Calaveras County is a small rural county, with a population of 45,029. The county is over 1,000 square miles with more than 80% residents living in unincorporated areas. Angles Camp is the only incorporated city in Calaveras County.

In Fiscal Year 2022-2023, the Plan had 1,681 Medi-Cal beneficiaries receiving Behavioral Health Services.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS SMHS audit for the period of July 1, 2022, through June 30, 2023. The audit was conducted from January 9, 2024, through January 19, 2024. The audit consisted of document review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on May 8, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On May 23, 2024, the Plan submitted a response after the Exit Conference. The results of evaluation of the Plan's response are reflected in this report.

The audit evaluated seven categories of performance: Network Adequacy and Availability of Services, Care Coordination and Continuity of Care, Quality Assurance and Performance Improvement, Access and Information Requirements, Coverage and Authorization of Services, Beneficiary Rights and Protection, and Program Integrity.

The prior DHCS triennial compliance review, (covering Fiscal Year 2017 through 2020), identified deficiencies incorporated in the Corrective Action Plan. This year's audit included a review of documents to determine implementation and effectiveness of the Plan's corrective actions.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous review.

The summary of the findings by category follows:

Category 1 – Network Adequacy and Availability of Services

The Plan has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need Therapeutic Foster Care (TFC). The Plan did not ensure the assessment for the need of TFC services to children and youth who met beneficiary access and medical necessity criteria for SMHS.

The Plan is required to provide or arrange TFC services to all children and youth who meet beneficiary access and medical necessity criteria for SMHS. The Plan did not ensure the provision of TFC services through a network of appropriate TFC providers.

The Plan is required to certify, or use another Plan's certification documents to certify, the organizational providers that subcontract with the Plan to provide SMHS. The Plan did not ensure timely certification and recertification of its subcontracted providers.

Category 2 – Care Coordination and Continuity of Care

There were no findings noted for this category during the audit period.

Category 3 - Quality Assurance and Performance Improvement
The Plan is required to implement mechanisms to monitor the safety and effectiveness of medication practices. The Plan did not implement mechanisms to monitor the safety and effectiveness of medication practices.

The Plan is required to adopt practice guidelines. The Plan did not adopt practice guidelines.

The Plan is required to disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. The Plan did not demonstrate that it disseminates the guidelines to all affected providers, and, upon request, to beneficiaries and potential beneficiaries.

Category 4 – Access and Information Requirements

There were no findings noted for this category during the audit period.

Category 5 – Coverage and Authorization of Services

The Plan is required to establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services and shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions. The Plan did not establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services.

The Plan is required to make an expedited authorization decision and provide notice as expeditiously as the beneficiary's heath condition requires, no later than 72 hours after receipt of the request for service. The Plan did not make expedited authorization decisions within 72-hours of receipt of the request.

Category 6 – Beneficiary Rights and Protection

The Plan is required to ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. The Plan did not demonstrate that it has processes in place to ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal.

Category 7 – Program Integrity

The Plan is required to implement and maintain written policies for all employees of the Plan, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers. The Plan did not implement and maintain written policies that provide detailed information about the False Claims Act and other

Federal and State Laws, including information about rights of employees to be protected as whistleblower.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted this audit of the Plan to ascertain that medically necessary services provided to beneficiaries comply with federal and state laws, Medi-Cal regulations and guidelines, and the state's SMH(S) Contract.

PROCEDURE

The audit was conducted from January 9, 2024, through January 19, 2024, for the audit period of July 1, 2022, through June 30, 2023. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine the effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan representatives.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and TFC Determination: nine children and youth assessments were reviewed for criteria and service determination.

ICC/IHBS Provision of Services: Nine children and youth beneficiary files were reviewed for the provision of ICC and/or IHBS services.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Ten beneficiary files were reviewed for evidence of a warm handoff following hospitalization discharge back to the Plan.

Category 3 - Quality Assurance and Performance Improvement

No verification study was conducted.

Category 4 – Access and Information Requirements

Access Line Test Calls: Five test calls requesting information about SMHS and how to treat an urgent condition were made to the Plan's statewide 24/7 toll-free number to confirm compliance with regulatory requirements; two test calls requesting information about the beneficiary problem resolution and fair hearing processes were made to the

Plan’s statewide 24/7 toll-free number to confirm compliance with regulatory requirements.

Access Test Call Log: Five required test calls were made and review of Plan’s call log to ensure logging of each test call and confirm the log contained all required components.

Category 5 – Coverage and Authorization of Services

Authorizations: 11 beneficiary files were reviewed for evidence of appropriate treatment authorization process including the concurrent review process.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: One grievance was reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review.

There were no reported appeals during the audit period.

Category 7 – Program Integrity

No verification study was conducted.

❖ COMPLIANCE AUDIT FINDINGS ❖

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CATEGORY 1 – NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

1.2	Children's Services

1.2.1 Assessment for the Need of TFC Services

The Plan is required to provide or arrange, and pay for, TFC services for beneficiaries under the age of 21. *(Contract, Exhibit A, Attachment 2, Provision 2(A)(13))*

The Plan has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need TFC. *(Behavioral Health Information Notice (BHIN) 21-073, Criteria for Beneficiary Access to SMHS, Medical Necessity and other Coverage Requirements; Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, (3rd ed., Jan. 2018), pp. 11 & 34.)*

Plan policy *ICC, IHBS, and TFC Determination and Delivery (Revised 11/2023)* outlines requirements for the determination and delivery of ICC, IHBS, and TFC services. The policy states, the Plan will use the ICC/IHBS/TFC Assessment tool to determine if a child or youth meets criteria and qualifies for TFC. The Plan makes individualized determinations of need for TFC services. Additionally, TFC is most appropriate for children/youth with more intensive needs or at risk or placement in residential or hospital settings.

Finding: The Plan did not ensure the assessment for the need of TFC services to children and youth who met beneficiary access and medical necessity criteria for SMHS.

Although the Plan has developed an Assessment Tool, it did not implement the requirement to assess for TFC services. The Assessment Tool did not contain any assessment for TFC services. The Plan has policies and procedures in place outlining the requirement to provide TFC for children and youth that meet medical necessity criteria for TFC; however, it has not implemented its policies and procedures to assess and provide TFC services.

In an interview, the Plan stated that it had not provided TFC services due to lack of Plan staff to assess the need and providers capable of rendering this type of service. In addition, the Plan stated TFC may be a burden on providers and foster parents due to the level of responsibility and detail the services require.

The Plan acknowledged providing TFC services is a contractual requirement yet had not provided TFC services.

When the Plan does not determine the need for TFC services, children and youth may not receive necessary behavioral health services and resources.

This is a repeat finding of the 2020-2021 review - Network Adequacy and Availability of Services.

Recommendation: Implement policies and procedures to ensure children and youth who meet beneficiary access criteria for SMHS are assessed to determine if TFC services are needed.

1.2.2 Provision of TFC Services

The Plan is required to provide, arrange, and pay for, medically necessary covered SMHS to beneficiaries. *(Contract, Exhibit A, Attachment 2)*

The Plan must provide TFC services to all children and youth who meet beneficiary access criteria for SMHS as medically necessary. (*BHIN 21-073*; *Criteria for Beneficiary Access to SMHS, Medical Necessity and other Coverage Requirements; Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (3rd ed., Jan. 2018), pp. 34.)*

The Plan is required to maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract for all beneficiaries. *(Contract, Exhibit A, Attachment 8(3)(B))*

Plan policy *ICC, IHBS, and TFC Determination and Delivery (Revised 11/2023)* outlines guidance and information for the determination and delivery of ICC, IHBS, and TFC services. TFC must be provided to all children and youth who meet criteria for TFC. There must be a Child and Family Team in place to guide TFC service provision. In addition, TFC is best appropriate for children with more intensive needs or who are at risk of placement in a residential or hospital setting, but who will be better serviced in the home or community setting.

Finding: The Plan did not ensure the provision of TFC services through a network of appropriate TFC providers.

In an interview, the Plan stated that TFC services are not currently available as it does not have any TFC service providers. The Plan has not been successful recruiting

TFC providers due to a small foster care patient demographic. In addition, the Plan was unable to provide documentation of a TFC recruitment effort during the audit period.

When the Plan does not contract with TFC providers, it cannot ensure the provision of medically necessary TFC services for children and youth in need of such services.

This is a repeat finding of the 2020-2021 review - Network Adequacy and Availability of Services.

Recommendation: Implement policies and procedures and referral process to ensure TFC services are provided.

1.4	Provider Selection and Monitoring

1.4.1 Certification & Recertification of Subcontracted Providers

The Plan is required to certify, or use another Plan's certification documents to certify, the organizational providers that subcontract with the Plan to provide SMHS. (Contract, Exhibit A, Attachment 8, sec. 8(D).)

Plan policy *Monitoring of Network Providers (Revised 10/2023)* outlines guidance and information on the monitoring of performance of the Plan's subcontractors and network providers, including provisions to ensure compliance with certification and re-certifications are met. The Plan's Quality Management (QM) team maintains a Provider Credentialing spreadsheet on monthly basis to ensure re-certifications and termination of contracts occur prior to expiration. The Plan certifies or uses another Plan's certification documents to certify the organizational providers that subcontract with the Plan to provide covered services in accordance with State regulations. In addition, an on-site review is made a part of the certification process.

Finding: The Plan did not implement certification requirements for subcontract providers that provide SMHS.

The DHCS Provider Monitoring report revealed 14 of the 21 provider sites were not certified.

In an interview, the Plan stated it did not certify and re-certify all providers due to having insufficient staffing resources. The Plan acknowledged monitoring provider certification due dates yet did not have the staff to provide timely certifications and/or re-certifications. The Quality Management team that is charged with overseeing the process was understaffed during the audit period.

If the Plan does not certify its providers, beneficiaries may receive poor mental health outcomes.

This is a repeat finding of the 2020-2021 review - Network Adequacy and Availability of Services.

Recommendation: Implement effective policies and procedures to ensure timely certification and re-certification of subcontracted providers.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: CALAVERAS COUNTY MENTAL HEALTH PLAN

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CATEGORY 3 – QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

3.1	Quality Assessment and Performance Improvement Program

3.1.1 Monitoring Medication Practices

The Plan shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be: 1) Under the supervision of a person licensed to prescribe or dispense medication. 2) Performed at least annually. 3) Inclusive of medications prescribed to adults and youth. *(Plan Contract, Ex. A, Att. 5, sec. 1(H).)*

Plan policy *Medication and Monitoring (Dated 06/2004)* outlines how the Plan's medication monitoring process ensures and improves the quality of psychotropic medication prescribing and use. The medication monitoring process is conducted under the supervision of person licensed to prescribe or dispense prescription drugs. The Medication Monitoring Review Form is utilized when assessing clients' charts. Results of the Plan's Medication Monitoring Review is monitored by the Plan Quality Management Specialists (QMS) team or designee on an ongoing basis and reports identified trends to the Quality Improvement Committee (QIC) on an annual basis.

Finding: The Plan did not implement mechanisms to monitor the safety and effectiveness of medication practices.

In an interview, the Plan acknowledged not having effective mechanisms to monitor the safety and effectiveness of medication practices. The Plan's contracted psychiatrist was assigned to perform medication monitoring; however, the psychiatrist was uncomfortable reviewing medication practices. As a result, no medication monitoring was performed during the audit period. In addition, the Plan's electronic health record (EHR) was outdated and did not have the capability to pull medication monitoring results. Due to staff shortages, the Plan was not able to obtain an in-house psychiatrist to perform medication monitoring until after the audit period.

When the Plan does not implement mechanisms to monitor the safety and effectiveness of medication practices, it can result in harm and/or poor mental health outcomes for beneficiaries.

This is a repeat finding of the 2020-2021 review - Quality Assurance and Performance Improvement.

Recommendation: Implement mechanisms to monitor the safety and effectiveness of medication practices.

3.5	Practice Guidelines

3.5.1 Adopt Practice Guidelines

The Plan is required to adopt practice guidelines. The guidelines shall be based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field; consider the needs of the beneficiaries; adopted in consultation with network providers; are reviewed and updated periodically as appropriate. *(Plan Contract, Ex. A, Att. 5, sec. 6(A); 42 C.F.R. § 438.236(b); CCR, tit. 9, § 1810.326.)*

Plan policy *Dissemination of Practice Guidelines (Effective 06/01/2021)* provides guidance and instruction on the dissemination of practice guidelines to affected providers, and, upon request, to beneficiaries and potential beneficiaries. The practice guidelines are adopted in consultation with contracting health care professionals and reviewed/updated periodically. The Plan adopts the practice guidelines in compliance with *Code of Federal Regulations (CFR), Title 42, section 438.236(b) and California Code of Regulations, Title 9, section 1810.326.*

Finding: The Plan did not adopt practice guidelines.

In an interview, the Plan confirmed it does not have any formal practice guidelines. The Plan stated it has not yet developed practice guidelines because it lacks staff, in addition to, lack of clinical supervisors to provide guidance for practice guideline development.

If the Plan does not adopt practice guidelines, it may result in lack of informed healthcare decisions and/or poor mental health outcomes for beneficiaries.

Recommendation: Adopt practice guidelines in accordance with the contract.

3.5.2 Dissemination of Practice Guidelines

The Plan shall disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. *(Plan Contract, Ex. A, Att. 5, sec. 6(C); 42 C.F.R. § 438.236(c); CCR, tit. 9, § 1810.326.)*

Plan policy *Dissemination of Practice Guidelines (Effective 06/01/2021)* provides guidance and instruction on the dissemination of practice guidelines to affected providers, and, upon request, to beneficiaries and potential beneficiaries. The Plan adopts the practice guidelines in compliance with *Code of Federal Regulations (CFR), Title 42, section 438.236(b) and California Code of Regulations, Title 9, section*

1810.326. The practice guidelines are adopted in consultation with contracting health care professionals and reviewed/updated periodically.

Finding: The Plan did not demonstrate that it disseminates the guidelines to all affected providers, and, upon request, to beneficiaries and potential beneficiaries.

In an interview, the Plan confirmed it does not have any formal practice guidelines to disseminate to affected providers, beneficiaries, or potential beneficiaries. The Plan stated it has not yet developed practice guidelines because it lacks staff, in addition to, lack of clinical supervisors to provide guidance for practice guideline development.

If the Plan does not disseminate the guidelines to all affected providers, and, upon request, to beneficiaries and potential beneficiaries, it may result in lack of informed healthcare decisions.

This is a repeat finding of the 2020-2021 review - Quality Assurance and Performance Improvement.

Recommendation: Implement effective policies and procedures to ensure that it disseminates the guidelines to all affected providers, and, upon request, to beneficiaries and potential beneficiaries.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: CALAVERAS COUNTY MENTAL HEALTH PLAN

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CATEGORY 5 – COVERAGE AND AUTHORIZATION OF SERVICES

5.1	Authorization-General Requirements

5.1.1 Authorization of Psychiatric Inpatient Hospital Services

The Plan is required to establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services and shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions. Within 24 hours of admission of a Medi-Cal beneficiary for psychiatric inpatient hospital services, the hospital, or Psychiatric Health Facilities (PHF) shall provide the responsible county (or Mental Health Plan of beneficiary) the beneficiary's admission orders, initial plan of care, a request to authorize the beneficiary's treatment, and a completed face sheet *(BHIN 22-017; Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services 1.a.; CFR, tit. 42, 438.210(b)(1), 438.210(b)(2)(i-ii)).*

Finding: The Plan did not establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services.

The verification study revealed six of the 11 medical charts wherein the psychiatric inpatient hospital did not provide required admission documentation to the Plan within 24 hours.

In an interview, the Plan acknowledged it was unaware of the requirement that within 24 hours of inpatient SMHS admission to hospitals or PHFs, the hospital or PHF must provide the Plan with the beneficiary's admission orders, initial Plan of care, a request to authorize the beneficiary's treatment, and a completed face sheet.

Furthermore, the Plan acknowledged this requirement needs to be written within Plan policy and procedures.

If the Plan does not establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services, it can negatively impact a beneficiary's ability to receive timely and medically necessary services.

Recommendation: Establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services.

5.1.2 Expedited Authorizations

The Plan is required to decide whether to grant, modify, or deny the hospital's or PHF's initial treatment authorization request and communicate the decision to the requesting hospital or PHF per managed care requirements for expedited authorizations following receipt of all information specified in 1.a. of BHIN 22-017. The Plan must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and not later than 72 hours after receipt of the request for services. *(BHIN 22-017; Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services 1.b.)*

Finding: The Plan did not make expedited authorization decisions within 72-hours of receipt of the request for services.

The verification study revealed four of 11 medicals charts did not include a timely notice after receipt of request for services.

In an interview, the Plan acknowledged it was not able to make expedited authorization decisions due to inadequate staffing resources. The Plan has one employee who is qualified to make authorization decisions. Without backup staff, the Plan may not be able to meet timeliness of authorization decisions. The Plan stated it has attempted to fill empty positions; however, it has experienced challenges for hiring and retaining personnel due to budgeting, salary rates, and availability of housing.

If the Plan does not provide timely authorizations for psychiatric inpatient hospital services, it may negatively impact a beneficiary's ability to receive timely and medically necessary services.

Recommendation: Ensure all expedited authorization decisions are determined within 72-hours of receipt of the request for services.

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CATEGORY 6 – BENEFICIARY RIGHTS AND PROTECTIONS

6.2	Handling Grievances and Appeals

6.2.1 Expedited Resolution and Appeal

The Plan is required to ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. *(42 C.F.R. § 438.410(b), Contract, Ex. A, Att. 12, sec. 6(B)(3).)*

Plan policy *Problem Resolution Process (Revised Date, 9/17/2019)* provides the process and procedures for resolving beneficiary grievances and appeals. The policy ensures, if a consumer feels uncomfortable acting in their own behalf regarding filing and/or resolving an appeal, the consumers can authorize a provider to file the appeal on behalf of the beneficiary. In addition, appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

Finding: The Plan did not demonstrate that it has processes in place to ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal.

Document review revealed the Plan did not have evidence of demonstrating that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. The Plan acknowledged not having this requirement within training materials and beneficiary brochures.

In an interview, the Plan stated this lack of written policy and procedure was an oversight. The Plan could not provide written nor practice evidence of meeting this requirement. The Plan acknowledged the need to include this requirement within policies and procedures in the future.

If the Plan does not demonstrate processes in place to ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal, providers may not advocate on behalf of the beneficiary's best interest.

This is a repeat finding of the 2020-2021 review - Beneficiary Rights and Protections.

Recommendation: Implement policies and procedures to ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal.

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CATEGORY 7 – PROGRAM INTEGRITY

7.1	Compliance Program

7.1.1 False Claims Act and Whistleblower Policy and Procedure

The Plan is required to implement and maintain written policies for all employees of the Plan, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers. *(Plan Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(6).)*

Plan policy *Compliance Overview, Program Integrity (Revised 02/2023)* provides the process and procedures on how the Plan incorporates industry standards to detect, respond, and prevent violations of State and Federal statutes and regulations. The Policy ensures administrative and management arrangements or procedures, including a mandatory compliance plan that are designed to guard against fraud and abuse. Plan staff can report concerns to Plan hotlines, the Office of Inspector General (OIG) and Medi-Cal.

Finding: The Plan did not implement and maintain written policies that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers.

In an interview, the Plan acknowledged it does not have any policy and procedures outlining false claims act and protection as whistleblowers. The Plan stated it has a confidential and whistleblower hotline for staff and contractors to report fraud, waste, or abuse, however, these hotlines are not monitored due to lack of staffing. The Plan is unaware of any concerns of fraud, waste, or abuse during the audit period.

If the Plan does not implement policies regarding the False Claims Act and employee whistleblower protection may result in unreported fraud, waste, and abuse and/or fear of retaliation.

This is a repeat finding of the 2020-2021 review - Program Integrity.

Recommendation: Implement and maintain written policies for all employees of the Plan, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers.