DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

April 10, 2023

THIS LETTER SENT VIA EMAIL TO: rwhite@sbcmh.org

Ms. Rachel White, Assistant Director
San Benito County Behavioral Health Services
1131 Community Parkway
Hollister, CA 95023

SUBJECT: ANNUAL COUNTY COMPLIANCE SECTION DMC-ODS FINDINGS REPORT

Dear Assistant Director White:

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) and the terms of the Intergovernmental Agreement operated by San Benito County.

The County Compliance Section (CCS) within the Audits and Investigations Division (A&I) of DHCS conducted a review of the County's compliance with contract requirements based on responses to the monitoring instrument, discussion with county staff, and supporting documentation provided by the County. Enclosed are the results of San Benito County's Fiscal Year 2022-23 DMC-ODS compliance review. The report identifies deficiencies, required corrective actions, advisory recommendations, and referrals for technical assistance.

San Benito County is required to submit a Corrective Action Plan (CAP) addressing each compliance deficiency (CD) to the Medi-Cal Behavioral Health – Oversight and Monitoring Division (MCBH-OMD), County/Provider Operations and Monitoring Branch (CPOMB) Liaison by 6/12/2023. Please use the enclosed CAP form to submit the completed CAP and supporting documentation via the MOVEit Secure Managed File Transfer System. For instructions on how to submit to the correct MOVEit folder, email MCBHOMDMonitoring@dhcs.ca.gov.

If you have any questions, please contact me at becky.counter@dhcs.ca.gov.

Sincerely,

Becky Counter | Analyst

Distribution:

To: Assistant Director White,

Cc: Mateo Hernandez, Audits and Investigations, Medical Review Branch Acting Chief
Catherine Hicks, Audits and Investigations, Behavioral Health Compliance Section Chief
Ayesha Smith, Audits and Investigations, Behavioral Health Compliance Unit Chief
Michael Bivians, Audits and Investigations, County Compliance Monitoring II Chief
Cindy Berger, Audits and Investigations, Provider Compliance Unit Chief
Sergio Lopez, County/Provider Operations Monitoring Section I Chief
Tony Nguyen, County/Provider Operations Monitoring Section II Chief
MCBHOMDMonitoring@dhcs.ca.gov, County/Provider Operations and Monitoring Branch
Elizabeth Lopez, San Benito County SUD Program, Clinical Supervisor

COUNTY REVIEW INFORMATION

County:
San Benito

County Contact Name/Title:
Elizabeth Lopez/SUD Program Clinical Supervisor

County Address:
1131 Community Parkway
Hollister, CA 95023

County Phone Number/Email:
(831) 636-4020
elopez@sbcmh.org

Date of DMC-ODS Implementation:
7/1/2019

Date of Review:
2/23/2023

Lead CCM Analyst:
Becky Counter

Assisting CCM Analyst:
N/A

Report Prepared by:
Becky Counter

Report Approved by:
Ayesha Smith

REVIEW SCOPE

I. Regulations:
   a. Special Terms and Conditions (STCs) for California Advancing & Innovating Medi-Cal (CalAIM) 1915(b) Waiver
   b. Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 438; section 438.1 through 438.930: Managed Care
   c. California Code of Regulations, Title 9, Division 4: Department of Drug and Alcohol Programs
   d. California Health and Safety Code, Chapter 3 of Part 1, Division 10.5: Alcohol and Drug Programs
   e. California Welfare and Institutions Code, Division 9, Part 3, Chapter 7, sections 14000 et seq., in particular but not limited to sections 14100.2, 14021, 14021.5, 14021.6, 14021.51-14021.53, 14124.20-14124.25, 14043, et seq., 14184.100 et seq. and 14045.10 et seq.: Basic Health Care

II. Program Requirements:
   a. Fiscal Year (FY) 2021-22 Intergovernmental Agreement (IA)
   b. Fiscal Year (FY) 2022-23 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 2/23/2023. The following individuals were present:

- Representing DHCS:
  Becky Counter, Analyst

- Representing San Benito County:
  Rachel White, Assistant Director
  Elizabeth Lopez, SUD Program Clinical Supervisor
  Regina Kendall, QI Supervisor
  Dr. Wayne Clark, Independent Contractor Advisor
  Maxe Cendana, QI Supervisor
  Rumi Saikia, QI Supervisor
  Nancy Callahan, Consultant

During the Entrance Conference, the following topics were discussed:

- Introductions
- Overview of review process
- San Benito County of services provided

Exit Conference:

An Exit Conference was conducted via WebEx on 2/23/2023. The following individuals were present:

- Representing DHCS:
  Becky Counter, Analyst

- Representing San Benito County:
  Rachel White, Assistant Director
  Elizabeth Lopez, SUD Program Clinical Supervisor
  Regina Kendall, QI Supervisor
  Dr. Wayne Clark, Independent Contractor Advisor
  Maxe Cendana, QI Supervisor
  Rumi Saikia, QI Supervisor
  Nancy Callahan, Consultant

During the Exit Conference, the following topics were discussed:

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

SUMMARY OF FY 2022-23 COMPLIANCE DEFICIENCIES (CD)

Section:		Number of CDs
1.0	Availability of DMC-ODS Services	5
2.0	Coordination of Care Requirements	3
3.0	Quality Assurance and Performance Improvement	5
4.0	Access and Information Requirements	7
5.0	Beneficiary Rights and Protections	2
6.0	Program Integrity	3

CORRECTIVE ACTION PLAN (CAP)

Pursuant to the Intergovernmental Agreement, Exhibit A, Attachment I, Part III, Section QQ 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 2022-23 CAP:

a) A list of action steps to be taken to correct the CD.
b) The name of the person who will be responsible for corrections and ongoing compliance.
c) Provide a specific description on how ongoing compliance is ensured.
d) 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 1.2.1:
Intergovernmental Agreement Exhibit A, Attachment I, II, H, 6, i-v

i. The Contractor and its subcontractors shall not knowingly have a relationship of the type described in paragraph (iii) of this subsection with the following:
   a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
   b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section.

ii. The Contractor and its subcontractors shall not have a relationship with an individual or entity that is excluded from participation in any Federal Health Care Program under section 1128 or 1128A of the Act.

iii. The relationships described in paragraph (i) of this section, are as follows:
   a. A director, officer, or partner of the Contractor.
   b. A subcontractor of the Contractor, as governed by 42 CFR §438.230.
   c. A person with beneficial ownership of five percent or more of the Contractor's equity.
   d. A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Agreement.

iv. If the Department finds that the Contractor is not in compliance, the Department:
   a. Shall notify the Secretary of the noncompliance.
   b. May continue an existing Agreement with the Contractor unless the Secretary directs otherwise.
   c. May not renew or otherwise extend the duration of an existing Agreement with the Contractor unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliations.
   d. Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act.

v. The Contractor shall provide the Department with written disclosure of any prohibited affiliation under this section by the Contractor or any of its subcontractors.

Findings: The Plan did not provide evidence of practice to demonstrate compliance with identifying Plan and subcontracted network providers knowingly having prohibited relationships with:

- An individual or entity debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual or entity defined as an affiliate of an individual or entity debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual or entity excluded from participation in Federal Health Care Program under section 1128 or 1128A of the Act.

CD 1.2.2:

Intergovernmental Agreement Exhibit A, Attachment I, III, J, 3

3. The Contractor shall only select providers that have a Medical Director who, prior to the delivery of services under this Agreement, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a "limited" categorical risk within a year prior to serving as a Medical Director under this Agreement, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

Findings: The Plan did not provide evidence to demonstrate Plan and subcontracted network providers only select providers that have a Medical Director who:

- Enrolled with DHCS under applicable state regulations.
- Screened as a "limited" categorical risk within a year prior to serving as a Medical Director.
- Signed a Medicaid provider agreement with DHCS.

CD 1.3.1:

Intergovernmental Agreement Exhibit A, Attachment I, III, B, 1, v

v. 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 to demonstrate San Benito County's physician received the annual five (5) hours of continuing medical education in addiction medicine. Specifically:

- The continuing medical education submitted for calendar year 2021 for San Benito County's physician, Dr Huang, was not provided.

The Plan provided evidence to demonstrate only one (1) of the two (2) physicians from subcontracted network providers received the annual five (5) hours of continuing medical education in addiction medicine, Specifically:

- The continuing medical education submitted for calendar year 2021 for Valley Health Associates physician, Dr. Castellanos, totaled 30.5 hours.
- The continuing medical education was not provided from a second requested provider for calendar year 2021.

CD 1.3.2:

Intergovernmental Agreement Exhibit A, Attachment I, III, B, 1, vi

vi. 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 to demonstrate San Benito County's non-physician professional staff (LPHA) received certified CEU certificates for their annual five (5) hours of continuing education units (CEU) in addiction medicine during calendar year 2021.

The Plan did not provide the requested evidence to demonstrate six (6) subcontractor non-physician professional staff (LPHA) received the annual five (5) hours of continuing education units (CEU) in addiction medicine during calendar year 2021.

CD 1.3.4:

Intergovernmental Agreement Exhibit A, Attachment I, III, MM, 3, ii, c

c. The Contractor shall ensure that all personnel who provide WM services or who monitor or supervise the provision of such service shall meet additional training requirements set forth in BHIN 21-001 and its accompanying exhibits.

BHIN 21-001

Findings: The Plan did not provide evidence to demonstrate all personnel who provide Withdrawal Management (WM) services or who monitor or supervise the provision of such service meet the additional training set forth in BHIN 21-001, specifically;

- Certified in cardiopulmonary resuscitation;
- Certified in first aid;
- Trained in the use of Naloxone;
- Six (6) hours of orientation training for all personnel providing WM services, monitoring and supervising the provision of WM services;
- Repeated orientation training within 14-days for returning staff following a 180 continuous day break in employment;
- Eight (8) hours of training annually that covers the needs of residents who receive WM services;
- Training documentation must be maintained in personnel records; and

- Personnel training shall be implemented and maintained by the licensee pursuant to CCR, Title 9, Section 10564(k).

Category 2: COORDINATION OF CARE

A review of the coordination of care requirements and continuity of care was conducted to ensure compliance with applicable regulations, and standards. The following deficiencies in the coordination of care requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 2.1.3:
Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 13, i
13. Youth Treatment Guidelines
i. Contractor shall follow the guidelines in Document 1V, incorporated by this reference, "Youth Treatment Guidelines," in developing and implementing adolescent treatment programs funded under this Exhibit, until such time new Youth Treatment Guidelines are established and adopted. No formal amendment of this Agreement is required for new guidelines to be incorporated into this Agreement.

Adolescent Best Practices Guide

3.1.6 Case Management and Care Coordination

Adolescents are often involved in multiple systems while in or on their path to treatment and throughout their recovery (see Systems Collaboration section for additional information). Effective adolescent services coordinate with the adolescent's family and with professionals from the various systems with which he or she interacts (e.g., mental health, physical health care, education, social services, child welfare, and juvenile justice). Involvement of these professionals, as identified by the team, assists in developing and executing a comprehensive treatment plan. Case managers (e.g., care coordinators) provide continuous support for the adolescents, ensuring there are linkages

Findings: The Plan did not provide evidence of practice to demonstrate Plan and subcontracted network provider case managers and care coordinators provide continuous support for adolescent clients entering treatment.

The Plan did not provide evidence it ensures case managers and care coordinators provide continuous support for adolescent clients entering treatment with a system that includes interaction with following services:

- Adolescent's family.
- Professionals from Mental Health.
- Professionals from Physical Health care and
- Professionals from Educational Services.

CD 2.1.4:
Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 13, i
13. Youth Treatment Guidelines
    i. Contractor shall follow the guidelines in Document 1V, incorporated by this reference, "Youth Treatment Guidelines," in developing and implementing adolescent treatment programs funded under this Exhibit, until such time new Youth Treatment Guidelines are established and adopted. No formal amendment of this Agreement is required for new guidelines to be incorporated into this Agreement.

Adolescent Best Practices Guide

4.6 Transportation

> Access to safe, affordable transportation for adolescents with SUDs can increase their engagement and retention in treatment, aid in accessing other treatment-related services, and assist in achieving treatment and recovery plan goals. Transportation assistance may be accomplished in a variety of ways, such as provision of public transportation passes; and identification of and access to other community transportation resources (NASADAD, 2014).

Findings: The Plan did not provide evidence of practice to demonstrate access to safe, affordable transportation to assist with engagement and retention in treatment and assist in achieving recovery plan goals for adolescents.

CD 2.2.1:
Intergovernmental Agreement Exhibit A, Attachment I, II, E, 3, i-ii, a-e
i. The Contractor shall comply with the care and coordination requirements of this section.
ii. 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 their 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. 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.
d. Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.
e. 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.

Findings: The Plan did not provide evidence of practice to demonstrate implementation of procedures to deliver care and coordinate services for all of its beneficiaries, specifically:

- An ongoing source of care appropriate to needs and person or entity designated as primarily responsible for coordinating services accessed;
- Information on how to contact their designated person or entity;
- Coordinate services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;
- Coordinate services with the services the beneficiary receives from any other managed care organization;
- Coordinate services with the services the beneficiary receives in FFS Medicaid;
- Coordinate services with the services the beneficiary receives from community and social support providers.
- Coordinate 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;
- Coordinate with and ensure each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards; and
- Ensure 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.

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, RR, 5, iii
5. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:
   iii. Timeliness of services of the first dose of NTP services.

Findings: The Plan did not provide evidence to demonstrate monitoring network providers for accessibility of services as described in a QI Plan, specifically:
- Timeliness of services of the first dose of NTP services.

CD 3.2.4:
Intergovernmental Agreement Exhibit A, Attachment I, III, RR, 5, iv
5. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:
   iv. Access to after-hours care.

Findings: The Plan did not provide evidence to demonstrate monitoring network providers for accessibility of services as described in a QI Plan, specifically:
- Access to after-hours care.

CD 3.2.5:
Intergovernmental Agreement Exhibit A, Attachment I, III, RR, 5, vii
5. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:
   vii. Coordination of physical and mental health services with waiver services at the provider level.

Findings: The Plan did not provide evidence to demonstrate monitoring network providers for accessibility of services as described in a QI Plan, specifically:
- Coordination of physical and mental health services with wavier services at the provider level.

CD 3.3.2:
Intergovernmental Agreement Exhibit A, Attachment I, III, LL, 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.

CD 3.3.3:
Intergovernmental Agreement Exhibit A, Attachment, III, MM, 6, i, a-d

i. The DATAR business rules and requirements:
   a. The Contractor shall be responsible for ensuring that the Contractor-operated treatment services and all treatment providers with whom Contractor subcontracts or otherwise pays for the services, submit a monthly DATAR report in an electronic copy format as provided by DHCS.
   b. In those instances where the Contractor maintains, either directly or indirectly, a central intake unit or equivalent, which provides intake services including a waiting list, the Contractor shall identify and begin submitting monthly DATAR reports for the central intake unit by a date to be specified by DHCS.
   c. The Contractor shall ensure that all DATAR reports are submitted to DHCS by the 10th of the month following the report activity month.
   d. The Contractor shall ensure that all applicable providers are enrolled in DHCS' web-based DATAR program for submission of data, accessible on the DHCS website when executing the subcontract.

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

Category 4: ACCESS AND INFORMATION REQUIREMENTS

A review of the access and information requirements for the access line, language and format requirements, and general information was conducted to ensure compliance with applicable regulations and standards. The following deficiencies in access and information requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 4.1.1:
Intergovernmental Agreement Exhibit A, Attachment I, III, OO, 1
1. Contractor shall include instructions on record retention and include in any subcontract with providers the mandate to keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to W&I Code section 14124.1 and 42 CFR 438.3(h) and 438.3(u).

WIC 14124.1

Findings: The Plan did not provide evidence to demonstrate instructions on record retention and a mandate for all providers to keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to WIC 14124.1 and 42 CFR 438.3(h) and 438.3(u) are included in any subcontract with a network provider.

The Plan did not provide evidence to demonstrate Plan and subcontracted network providers ensure records are retained for ten years from the final date of the contract period between the County and the provider, from the date of completion of any audit or from the date the service was rendered, whichever is later, pursuant to WIC 14124.1 and CFR 438.3(h) and 438.3(u).

CD 4.1.2:
Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 1
1. The Contractor shall notify the Department of the termination of any subcontract with a certified provider, and the basis for termination of the subcontract, within two business days. The Contractor shall submit the notification using a Secure Managed File Transfer system specified by DHCS.

Findings: The Plan did not provide evidence to demonstrate a process to notify DHCS within two (2) business days regarding the termination, and the basis for the termination of a subcontract with a certified provider.

CD 4.2.1:
Intergovernmental Agreement Exhibit A, Attachment I, III, G, 3, xi
xi. 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.

Findings: The Plan did not provide evidence of practice to demonstrate it has an effective 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services.

CD 4.2.2:
Intergovernmental Agreement Exhibit A, Attachment I, III, G, 3, xi
xi. 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.

Findings: The Plan did not provide evidence to demonstrate prospective beneficiaries calling the 24/7 toll free number received information to access DMC-ODS services.

A minimum of two test calls were conducted for the Plan's 24/7 toll free number posted on the County's website. The responses to the test calls resulted in a barrier to access DMC-ODS services for prospective beneficiaries calling.

The test calls are summarized below:

Test Call 1: CCM analyst completed a test call on 1/9/23 at 4pm during business hours. This call was in compliance as the operator explained the details involved with the intake and assessment and asked if CCM analyst would like to speak with an SUD counselor. Then operator did try to assess if the caller was in crisis and stated that if there was a need for assistance in the future that this number could be used to access support 24/7. The operator tried to establish the caller's eligibility for Medi-Cal and provided information on the location of where group services and medication support services occur based on the information provided by the caller.

Test Call 2: CCM analyst completed a test call on 1/10/23 before business hours at 7am. This call was determined to be out of compliance because the live representative Rayna shared that she works for the after-hours answering service and did not have any information about scheduling or appointment information and it would be best to call back at 8am and speak with one of the Behavioral Health staff to obtain that information. Rayna shared that if this was in regard to suicidal thoughts that some counties have a mobile crisis. She checked on that information and determined that San Benito County does not have mobile crisis and stated that I could call the police for assistance. When CCM analyst asked about how to obtain other assistance or

information on substance abuse services after hours, Rayna brought up the Esperanza Center. However, when looking up that contact information, she noted that the hours were from 10-12 on Mondays and stated that this center did not offer any 24/7 access support. Rayna stated that the information she is provided is pretty generic and recommended that CCM analyst call back at 8am to Behavioral Health Services. Rayna then apologized for not being able to offer more information after hours.

CD 4.3.1:

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 8, i-iii, a-e, i-iv

8. Subcontractual Relationships and Delegation
    i. The requirements of this section apply to any contract or written arrangement that the Contractor has with any subcontractor.
    ii. Notwithstanding any relationship(s) that Contractor may have with any subcontractor, the Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this agreement.
    iii. All contracts or written arrangements between the Contractor and any subcontractor shall specify the following:
        a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.
        b. The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's Agreement obligations.
        c. The contract or written arrangement shall either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Department or the Contractor determine that the subcontractor has not performed satisfactorily.
        d. The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.
        e. The subcontractor agrees: —
            i. The Department, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's Contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Agreement at any time.
            ii. The subcontractor will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries.
            iii. The Department, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the subcontractor will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

iv. If the Department, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Department, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Findings: The Plan did not provide evidence to demonstrate contracts or written arrangements between the Plan and subcontractors, or subcontractor and providers, include all required elements, specifically:

- The Department, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the subcontractor will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

CD 4.3.2:

Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 15, i-xiii

15. Federal Law Requirements:
    i. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.
    ii. Title IX of the Education Amendments of 1972 (regarding education and programs and activities), if applicable.
    iii. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
    iv. Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.
    v. Age Discrimination in Employment Act (29 CFR Part 1625).
    vi. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.
    vii. Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
    viii. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
    ix. Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
    x. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.
    xi. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
    xii. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
    xiii. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

Intergovernmental Agreement Exhibit A, Attachment, III, CC, 18, i
18. Subcontract Provisions
    i. Contractor shall include all of the foregoing provisions in all of its subcontracts.

Findings: The Plan did not provide evidence to demonstrate all federal law requirements from the Intergovernmental Agreement, Exhibit A, Attachment I, III, CC, 15, i-xiii, foregoing provision is included in all subcontracts, specifically missing:

- Title IX of the Education Amendments of 1972.
- Executive Order 13166 (67 FR 41455).
- The Drug Abuse Office and Treatment Act of 1972.
- The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616).

CD 4.3.3:
Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 16, i-v
16. State Law Requirements:
    i. Fair Employment and Housing Act (Gov. Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (Cal. Code Regs., tit. 2, Div. 4 § 7285.0 et seq.).
    ii. Title 2, Division 3, Article 9.5 of the Gov. Code, commencing with Section 11135.
    iii. Cal. Code Regs., tit. 9, div. 4, chapter 8, commencing with §10800.
    iv. No state or Federal funds shall be used by the Contractor, or its subcontractors, for sectarian worship, instruction, and/or proselytization. No state funds shall be used by the Contractor, or its subcontractors, to provide direct, immediate, or substantial support to any religious activity.
    v. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Agreement or terminate all, or any type, of funding provided hereunder.

Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 18, i
18. Subcontract Provisions
    i. Contractor shall include all of the foregoing provisions in all of its subcontracts.

Findings: The Plan did not provide evidence to demonstrate all state law requirements from the Intergovernmental Agreement, Exhibit A, Attachment I, III, CC, 16, i-v, foregoing provision is included in all subcontracts, specifically missing:

- Fair Employment and Housing Act.
- Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
- Noncompliance with the requirements of nondiscrimination in services constitutes grounds for state to withhold payments or terminate all, or any type, of funding provided.

Category 5: BENEFICIARY RIGHTS AND PROTECTIONS

A review of the grievance and appeals was conducted to ensure compliance with applicable regulations and standards. The following deficiency in beneficiary rights and protections for regulations, standards, or protocol requirements was identified:

COMPLIANCE DEFICIENCY:

CD 5.1.1:
Intergovernmental Agreement Exhibit A, Attachment I, II, D, 1, i-iii, a-b

1. Beneficiary Rights (42 CFR §438.100).
    i. The Contractor shall have written policies guaranteeing the beneficiary's rights specified in 42 CFR 438.100.
    ii. The Contractor shall comply with any applicable Federal and state laws that pertain to beneficiary rights, and ensures that its employees and subcontracted providers observe and protect those rights.
    iii. Specific rights.
        a. The Contractor shall ensure that its beneficiaries have the right to:
            i. Receive information regarding the Contractor's PIHP and plan in accordance with 42 CFR §438.10.
            ii. Be treated with respect and with due consideration for his or her dignity and privacy.
            iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand.
            iv. Participate in decisions regarding his or her health care, including the right to refuse treatment.
            v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
            vi. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.
        b. The Contractor shall ensure that its beneficiaries have the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210.

Findings: The Plan did not provide evidence of practice to demonstrate Plan and subcontracted network providers' compliance with ensuring Beneficiary Rights (42 CFR § 438.100) requirements, specifically:

- Have written policies guaranteeing the beneficiary's rights specified in 42 CFR 438.100.

- Compliance with any applicable Federal and State laws that pertain to beneficiary rights.
- Receive information regarding the Contractor's PIHP and plan in accordance with 42 CFR §438.10.
- Be treated with respect and with due consideration for his or her dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
- If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.
- Ensuring that its beneficiaries have the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210.

CD 5.2.1:

Intergovernmental Agreement Exhibit A, Attachment I, II, L, 1-3, i-iii

1. The Contractor shall designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.
2. The Contractor shall adopt Discrimination Grievance procedures that ensure the prompt and equitable resolution of discrimination-related complaints. The Contractor shall not require a beneficiary to file a Discrimination Grievance with the Contractor before filing the grievance directly with DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.
3. The Discrimination Grievance Coordinator shall be available to:
    i. Answer questions and provide appropriate assistance to the Contractor staff and members regarding the Contractor's state and federal nondiscrimination legal obligations.
    ii. Advise the Contractor about nondiscrimination best practices and accommodating persons with disabilities.
    iii. Investigate and process any Americans with Disabilities Act, Section 504 of the Rehabilitation Act, section 1557 of the Affordable Care Act, and/or Gov. Code section 11135 grievances received by the Contractor.

Findings: The Plan did not provide evidence to demonstrate compliance with ensuring Discrimination Grievance program requirements, specifically:

- Requirement for a beneficiary to file a Discrimination Grievance with the Contractor before filing the grievance directly with DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

The Plan did not provide evidence to demonstrate the investigation of grievances related to any action prohibited by or out of compliance with federal or state nondiscrimination law based on the following characteristics, specifically:

- Sex
- Race
- Color
- Religion
- Ancestry
- National Origin
- Ethnic Group Identification
- Age
- Mental Disability
- Age
- Mental Disability
- Physical Disability
- Medical Condition
- Genetic Information
- Marital Status
- Gender
- Gender Identity
- Sexual Orientation.

Category 6: PROGRAM INTEGRITY

A review of the compliance program, service verification, and fraud reporting was conducted to ensure compliance with applicable regulations and standards. The following deficiencies in program integrity were identified:

COMPLIANCE DEFICIENCIES:

CD 6.1.1:
Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, iv

iv. The Contractor and all its subcontractors shall provide reports to the Department within 60 calendar days when it has identified payments in excess of amounts specified in this Agreement.

Findings: The Plan did not provide evidence to demonstrate Plan and subcontracted network provider compliance to provide reports to the DHCS within 60 calendar days upon identifying payments in excess of amounts specified in the Intergovernmental Agreement.

CD 6.1.2:
Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, ii, a, vii

vii. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.

Findings: The Plan did not provide evidence of practice to demonstrate compliance with implementation of agreements or procedures for monitoring and auditing of compliance risks, specifically:

- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks;
- Prompt response to compliance issues as they are raised;
- Investigation of potential compliance problems as identified in the course of self-evaluation and audits;
- Correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence; and
- Ongoing compliance with the requirements under this Agreement.

CD 6.2.1:
Intergovernmental Agreement Exhibit A, Attachment III, NN, 3

3. Suspected Medi-Cal fraud, waste, or abuse shall be reported to: DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov.

Findings: The Plan did not provide evidence to demonstrate Plan and subcontractor compliance with reporting suspected Medi-Cal fraud, waste, or abuse to DHCS Medi-Cal Fraud at (800) 822-6222 or Fraud@dhcs.ca.gov.

TECHNICAL ASSISTANCE

San Benito County did not request Technical Assistance during this review.