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

BRADLEY P. GILBERT
DIRECTOR

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GOVERNOR

June 1, 2020

Sent via e-mail to: Suzanne.Tavano@cchealth.org

Suzanne Tavano, PHN, PhD. Behavioral Health Director
Contra Costa County Behavioral Health Services
1220 Morella Ave. Suite 101
Martinez, CA 94533

SUBJECT: Annual County Compliance Report

Dear Director Tavano:

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 Contra Costa 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 Contra Costa 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.

Contra Costa 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 7/1/2020. 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.

Sincerely,

Michael Bivians
(916) 713-8966
michael.bivians@dhcs.ca.gov

Distribution:

To: Director Tavano,

CC: Mateo Hernandez, Audits and Investigations, Medical Review Branch Acting Chief
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Fatima Matal Sol, Contra Costa County Behavioral Health Services, Chief AOD Services
Mathew Luu, Contra Costa County Behavioral Health Services, Deputy Director

Lead CCU Analyst: Michael Bivians	**Date of Review:** April 2020 **Date of DMC-ODS Implementation:** 6/30/2017
County: Contra Costa	**County Address:** 1220 Morella Ave. Suite 101 Martinez, CA 94533
County Contact Name/Title: Fatima Matal Sol, Chief AOD Services	**County Phone Number/Email:** 925-335-3307 Fatima.MatalSol@cchealth.org
Report Prepared by: Michael Bivians	**Report Approved by:** Mayumi Hata

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 CDs:
1.0 Administration	1
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	2
8.0 Compliance	1

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 deficiency in administration requirements was identified:

COMPLIANCE DEFICIENCY:

CD 1.1:
Intergovernmental Agreement Exhibit A, Attachment I, III, A, 1, iv-v

iv. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.
v. Professional staff (LPHAs) shall receive a minimum of five (5) hours of continuing education related to addiction medicine each year.

Finding: The Plan did not provide the Plan's Medical Director's annual 5 hours of continuing medical education in addiction medicine.

6.0 MONITORING

The following deficiencies in monitoring were identified:

COMPLIANCE DEFICIENCIES:

CD 6.22:
Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, ii, b

ii. For consistency in the information provided to beneficiaries, the Contractor shall use:
b. The Department developed model beneficiary handbooks and beneficiary notices.

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, iv, a-b

iv. Beneficiary information required in this section may not be provided electronically by the Contractor unless all of the following are met:
a. The format is readily accessible;
b. The information is placed in a location on the Department or the Contractor's website that is prominent and readily accessible.

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, xiv, a

a. The Contractor shall utilize, and require its subcontracted providers to utilize, the state developed model beneficiary handbook.

MHSUDS Information Notice IN 18-043

MHPs must provide each beneficiary with the beneficiary handbook when the beneficiary first accesses services, and thereafter upon request. A template for this beneficiary handbook is included as an enclosure to this IN. The content of the beneficiary handbook includes information that enables the beneficiary to understand how to effectively access specialty mental health services. The template indicates fields where the MHP should insert county-specific information. MHPs will need to edit the template to add their county-specific information where indicated in the template.
The MHP must also give each beneficiary notice of any significant change.
The information contained in the beneficiary handbook at least 30 days before the intended effective date of the change.
Information in the beneficiary handbook must include the following at a minimum:

- Benefits provided by the MHP;
- How and where to access any benefits provided by the MHP, and how transportation is provided;
- The amount, duration, and scope of benefits available under the MHP contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled;
- How beneficiaries can obtain information from the MHP about how to access services, and procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care;
- The extent to which, and how, after-hours and emergency coverage are provided;
- What constitutes an emergency medical condition and emergency services;

- The fact that prior authorization is not required for emergency services and the beneficiary has a right to use any hospital or other setting for emergency care;
- Any restrictions on the beneficiary's freedom of choice among network providers;
- The extent to which, and how, beneficiaries may obtain benefits from out-of-network providers;
- Beneficiary rights and responsibilities;
- How to exercise an advance directive;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number that is answered 24 hours a day, seven days a week that can tell beneficiaries how to access specialty mental health services;
- Information on how to report suspected fraud or abuse; and
- Any other content required by the state.

The beneficiary handbook must also contain information on the grievance, appeal, and State Hearing procedures and timeframes, including:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State Hearing after the MHP has made a determination on a beneficiary's appeal that is adverse to the beneficiary; and
- The fact that, when requested by the beneficiary, benefits that the MHP seeks to reduce or terminate will continue if the beneficiary files an appeal or requests a State Hearing within the timeframes specified for filing.

The beneficiary handbook will be considered to be provided to the beneficiary if the MHP:

- Mails a printed copy of the beneficiary handbook to the beneficiary's mailing address;
- Provides the beneficiary handbook by email after obtaining the beneficiary's agreement to receive it by email;
- Posts the beneficiary handbook on the MHP's website and advises the beneficiary in paper or electronic form that the beneficiary handbook is available on the internet, including the applicable internet address, provided that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; and/or
- Provides the beneficiary handbook by any other method that can reasonably be expected to result in the beneficiary receiving the information.

All written materials for beneficiaries, including the beneficiary handbook, must use easily understood language and format, use a font size no smaller than 12 point, be available in alternative formats, e.g. large-print in an appropriate manner that takes into consideration the special needs of beneficiaries with disabilities or limited English proficiency, and include taglines and information about how to request auxiliary aids and services, including the provision of materials in alternative formats.

Each MHP must make its written materials that are critical to obtaining services available in the prevalent non-English languages in the MHP's county, including, at a minimum, the beneficiary handbook, provider directory, appeal and grievance notices, and denial and termination notices. Written materials must also be made available in alternative formats upon request of the beneficiary at no cost. Auxiliary aids and services, such as TTY/TDY and American Sign Language, must also be made available upon request of the beneficiary at no cost. Written

materials must include taglines in the prevalent non-English languages in the state, and in large-print, explaining the availability of written or oral translation to understand the information provided and the toll-free and TTY/TDY telephone number of the MHP's customer service unit. Oral interpretation must be available in all non-English languages, not just those identified as prevalent.

Finding: The Plan's beneficiary handbook was not placed in a location on the county's website that is prominent and readily accessible.

CD 6.23:

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, iv, a-b

iv. Beneficiary information required in this section may not be provided electronically by the Contractor unless all of the following are met:
  a. The format is readily accessible;
  b. The information is placed in a location on the Department or the Contractor's website that is prominent and readily accessible.

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, xviii, a

a. The Contractor shall make available in electronic form and, upon request, in paper form, the following information about its network providers:
  i. The provider's name as well as any group affiliation;
  ii. Street address(es);
  iii. Telephone number(s);
  iv. Website URL, as appropriate;
  v. Specialty, as appropriate;
  vi. Whether the provider will accept new beneficiaries;
  vii. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training; and
  viii. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

MHSUDS Information Notice 18-020

…the provider directory must also include the following information for each rendering provider:
- Type of practitioner, as appropriate;
- National Provider Identifier number;
- California license number and type of license; and,
- An indication of whether the provider has completed cultural competence training.

The provider directory should also include the following notation (may be included as a footnote); "Services may be delivered by an individual provider, or a team of providers, who is working under the direction of a licensed practitioner operating within their scope of practice. Only licensed, waivered, or registered mental health providers and licensed substance use disorder services providers are listed on the Plan's provider directory."

Plans may choose to delegate the requirement to list individuals employed by provider organizations to its providers. If the Plan delegates this requirement, the Plan's website must link to the provider organization's website and vice versa. Alternately, the Plan may elect to maintain this information at the county level. Ultimately, the Plan maintains responsibility for monitoring the network provider's compliance with these requirements.

Finding: The Plan's provider directory was not placed in a location on the county's website that is prominent and readily accessible.

CD 6.26

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
         SUD - Program, Policy and Fiscal Division
         Performance & Integrity Branch
         PO Box 997413, MS-2627
         Sacramento, CA 95899-7413

Finding: The Plan indicated a total of 19 DMC-ODS monitoring reports were sent to DHCS for SFY 2018-19. The Plan did monitor 19 of 28 Plan and sub-contracted providers for DMC-ODS programmatic and fiscal requirements. The Plan did submit 19 DMC-ODS programmatic and fiscal monitoring reports to DHCS within two weeks of report issuance.

7.0 PROGRAM INTEGRITY

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

COMPLIANCE DEFICIENCIES:

CD 7.44:
Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 6, i-ii

i. The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
   a) Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
   b) Ensure that physicians do not delegate their duties to non-physician personnel.
   c) Develop and implement written medical policies and standards for the provider.
   d) Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
   e) Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
   f) Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine the medical necessity of treatment for beneficiaries.
   g. Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

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

Finding: The Plan did not submit evidence of the written roles and responsibilities of the Medical Director from the following network provider, Contra Costa County Central County Adult Mental Health Services, DMC# 07PZ.

The written roles and responsibilities provided for the SUD program Medical Director of the Diablo Valley Ranch, DMC# 07OT, are missing the following criteria:

- Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
- Ensure that physicians do not delegate their duties to non-physician personnel.
- Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
- Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
- Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine the medical necessity of treatment for beneficiaries.
- Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

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.

Finding: The Plan's SUD program Medical Director's signed Code of Conduct for the R.E.A.C.H. Project, DMC# 0753, is missing the following element:

- Providing services beyond scope

The Plan's SUD program Medical Director's signed Code of Conduct for The Cole House, DMC# 07QU, is missing the following element:

- Cooperate with complaint investigations

The Plan's SUD program Medical Director's signed Code of Conduct for La Casa Ujima, DMC# 0712, 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
- 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

8.0 COMPLIANCE

The following program integrity deficiency in regulations, standards, or protocol requirements was identified:

COMPLIANCE DEFICIENCY:

CD 8.49:
Intergovernmental Agreement Exhibit A, Attachment I, III, F, 3, x

i. Have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services and make oral interpretation services available for beneficiaries, as needed.

Finding: The Plan's access line is non-compliant. Between the hours of 5 p.m. to 8 a.m., a caller using the Access Line will only hear a recorded message requesting the caller to leave a message. DHCS conducted two test calls on 4/16/2020; the first call at 4:17 p.m.; and the second call at 11:45 p.m.

Call 1 completed at 4:17 p.m.: This call is determined to be in compliance. An operator employed by Contra Costa County came on the line within 10 seconds following a prerecorded message. The operator listened to the problems presented by the caller and responded with positive statements. The operator attempted to verify the caller's Medi-Cal eligibility and discussed the need for the caller to be assessed before treatment can begin. The operator explained and overview of the intake process and provided appropriate contact information, phone numbers and addresses, for programs that can complete the assessment and intake. The operator transferred the caller to a provider site by phone.

Call 2 completed at 11:45 p.m.: This call is determined to be out of compliance. A recorded message was heard requesting the caller to leave a message. Leaving a message is the only option for a caller using the Access Line outside of business hours.

TECHNICAL ASSISTANCE

DHCS's County Compliance Unit Analyst will make referrals to the DHCS County Monitoring Liaison for the training and/or technical assistance area identified below:

Member Services: The Plan is requesting Technical Assistance with billing for Case Management during transitions to levels of care.