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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 21, 2022

Sent via e-mail to: jennifer.yasumoto@countyofnapa.org

Jennifer Yasumoto, Director
Napa County Health & Human Services Agency
2751 Napa Valley Corporate Dr.
Napa, CA 94558

SUBJECT: Annual DMC-ODS County Compliance Unit Findings Report

Dear Director Yasumoto:

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

Napa County is required to submit a Corrective Action Plan (CAP) addressing each compliance deficiency (CD) noted to the Medi-Cal Behavioral Health Division (MCBHD), Plan and Network Monitoring Branch (PNMB), County/Provider Operation and Monitoring Branch (CPOMB) Analyst by 5/23/2022. Please use the enclosed CAP form and submit the completed the CAP and supporting documentation via email to the CPOMB liaison at MCBHDMonitoring@dhcs.ca.gov.

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

Sincerely,

Becky Counter
(916) 713-8567

Audits and Investigations Division
Medical Review Branch
Behavioral Health Compliance Section
County Compliance Unit
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Amanda Jones, Napa County Assistant Deputy Director

COUNTY REVIEW INFORMATION

County:
Napa

County Contact Name/Title:
Amanda Jones/Assistant Deputy Director

County Address:
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Napa, CA 94558

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Date of DMC-ODS Implementation:
12/15/2017

Date of Review:
2/3/2022

Lead CCU Analyst:
Becky Counter

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

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

ENTRANCE AND EXIT CONFERENCE SUMMARIES

Entrance Conference:
An Entrance Conference was conducted via WebEx on 2/3/2022. The following individuals were present:

- Representing DHCS:
  Becky Counter, Associate Governmental Program Analyst (AGPA)

- Representing Napa County:
  Jennifer Yasumoto, Director
  Amanda Jones, Assistant Deputy Director
  Karen McElroy, Staff Services Analyst II

During the Entrance Conference, the following topics were discussed:

- Introductions
- Overview of the monitoring process
- Napa County overview of services

Exit Conference:
An Exit Conference was conducted via WebEx on 2/3/2022. The following individuals were present:

- Representing DHCS:
  Becky Counter, AGPA

- Representing Napa County:
  Amanda Jones, Assistant Deputy Director
  Karen McElroy, Staff Services Analyst II

During the Exit Conference, the following topics were discussed:

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

SUMMARY OF FY 2021-22 COMPLIANCE DEFICIENCIES (CD)

	Section:	Number of CD's
1.0	Availability of DMC-ODS Services	3
2.0	Coordination of Care	1
3.0	Quality Assurance and Performance Improvement	5
4.0	Access and Information Requirements	1
5.0	Beneficiary Rights and Protections	0
6.0	Program Integrity	4

CORRECTIVE ACTION PLAN (CAP)

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

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

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

The CPOMB liaison will monitor progress of the CAP completion.

Category 1: AVAILABILITY OF DMC-ODS SERVICES

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

COMPLIANCE DEFICIENCIES:

CD 1.4.4:
Intergovernmental Agreement Exhibit A, Attachment I, III, A, 1, ii

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

Findings: The Plan did not provide evidence of appropriate onsite orientation and training for two (2) non-professional staff hired by subcontractors during FY 2020-21 from the following network provider:

- Medmark

The Plan did not provide evidence of appropriate onsite orientation and training for two (2) professional/licensed staff hired by subcontractors during FY 2020-21 from the following network provider:

- Ujima

CD 1.4.8:
Intergovernmental Agreement Exhibit A, Attachment I, III, A, 1, iv

iv. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.

Findings: The Plan did not provide evidence demonstrating Napa County's physician, Dr. Althale, received the annual five (5) hours of continuing medical education units in addiction medicine. Specifically:

- The continuing medical education for calendar year 2019 for Napa County's physician, Dr. Althale, was not provided.

The Plan did not provide evidence demonstrating Aldea's physician, Dr. Shoulders, received the annual five (5) hours of continuing medical education in addiction medicine. Specifically:

- The continuing medical education for calendar year 2020 for Aldea's physician, Dr. Shoulders, was not provided.

The Plan did not provide evidence demonstrating the Medmark's physician, Dr. Kinnevey, received the annual five (5) hours of continuing medical education in addiction medicine. Specifically:

- The continuing medical education for calendar year 2019 for Medmark's physician, Dr. Kinnevey, was not provided.

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

Findings: The Plan did not provide evidence demonstrating the professional staff (LPHA) at Ujima's provider # 283019 received the annual five (5) hours of continuing education in addiction medicine. Specifically:

- The Plan submitted continuing education units for two (2) of three (3) subcontractor LPHA staff for calendar year 2019.

The Plan did not provide evidence demonstrating the professional staff (LPHA) at Ujima's provider # 283020 received the annual five (5) hours of continuing education in addiction medicine. Specifically:

- The Plan submitted continuing education units for zero (0) of three (3) subcontractor LPHA staff for calendar year 2019.
- The Plan submitted continuing education units for zero (0) of three (3) subcontractor LPHA staff for calendar year 2020.

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

- The Plan submitted continuing education units for two (2) of three (3) subcontractor LPHA staff for calendar year 2019.
- The Plan submitted continuing education units for zero (0) of three (3) subcontractor LPHA staff for calendar year 2020.

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 deficiency in the coordination of care requirements was identified:

COMPLIANCE DEFICIENCY:

CD 2.1.4:
Intergovernmental Agreement Exhibit A, Attachment I, II, E, 3, iv-v, a-e

iv. The Contractor shall implement mechanisms to comprehensively assess each Medicaid beneficiary identified by the Department as having special health care needs to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms shall use appropriate providers.
v. The Contractor shall produce a treatment or service plan meeting the criteria below for beneficiaries with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan shall be:
   a. Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary.
   b. Developed by a person trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR §441.301(c)(1) and (2).
   c. Approved by the Contractor in a timely manner, if this approval is required by the Contractor.
   d. In accordance with any applicable Department quality assurance and utilization review standards.
   e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).

Findings: The Plan did not provide evidence demonstrating County and subcontractor compliance with meeting the criteria for beneficiaries with special health care needs. The treatment or service plan was not:

- Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary.
- Approved by the Contractor in a timely manner, if this approval is required by the Contractor.
- In accordance with any applicable Department quality assurance and utilization review standards.
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).
- Developed by a person trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR §441.301(c)(1) and (2).

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 3.1.2:
Intergovernmental Agreement Exhibit A, Attachment I, II, E, 9, iii
iii. The Contractor shall ensure that all decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Findings: The Plan did not provide evidence demonstrating all decisions for beneficiary education are consistent with the Practice Guidelines.

CD 3.2.2:
Intergovernmental Agreement Exhibit A, Attachment I, III. PP, 6, i, a-j
1. Personnel files shall be maintained on all employees, contracted positions, volunteers, and interns, and shall contain the following:
   a. Application for employment and/or resume
   b. Signed employment confirmation statement/duty statement
   c. Job description
   d. Performance evaluations
   e. Health records/status as required by the provider, AOD Certification or CCR Title 9
   f. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
   g. Training documentation relative to substance use disorders and treatment
   h. Current registration, certification, intern status, or licensure
   i. Proof of continuing education required by licensing or certifying agency and program
   j. Provider's Code of Conduct.

Findings: The Plan did not provide evidence demonstrating personnel files are maintained on all County employees, volunteers and interns and contain the following:

- Job description
- Performance evaluations
- Health records/status as required by the provider, AOD Certification or CCR Title 9
- Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
- Training documentation relative to substance use disorders and treatment
- Proof of continuing education required by licensing or certifying agency and program
- Provider's Code of Conduct.

CD 3.2.3:

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

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

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

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

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

Findings: The Plan did not provide evidence demonstrating the written roles and responsibilities for Napa County's Medical Director, Dr. Karen Reluco, includes all required elements. The following required elements are missing, specifically:

- Signed and dated by the physician;
- Signed and dated by a provider representative.

The Plan did not provide evidence demonstrating the written roles and responsibilities for Aldea's Medical Director includes all required elements. The following required elements are missing, specifically:

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

The Plan did not provide evidence demonstrating the written roles and responsibilities for Center Point's Medical Director, Dr. David Smith, includes all required elements. The following required elements are missing, specifically:

- Signed and dated by the physician;
- Signed and dated by a provider representative.

CD 3.2.4:

Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 6, iii, a-i

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

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

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

Findings: The Plan did not provide evidence demonstrating the Code of Conduct for Ujima's Medical Director, Dr. MacMoran, includes all required elements. The following required elements are missing, specifically:

- Use of drugs and/or alcohol;
- Prohibition of social/business relationship with beneficiary's or their family members for personal gain;
- Prohibition of sexual contact with beneficiaries;
- Conflict of interest;
- Providing services beyond scope;
- Discrimination against beneficiary's or staff;
- Verbally, physically, or sexually harassing, threatening, or abusing beneficiary's, family members or other staff;
- Protection beneficiary confidentiality; and
- Cooperate with complaint investigations.

CD 3.2.5:

Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 9

9. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.

Findings: The Plan did not provide evidence of the implemented annual mechanism for monitoring the safety and effectiveness of medication practices is under the supervision of a person licensed to prescribe or dispense prescription drugs.

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 deficiency in access and information requirements was identified:

COMPLIANCE DEFICIENCY:

CD 4.1.3:
Intergovernmental Agreement Exhibit A, Attachment I, III, HH, 2

1. Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by using: The Complaint Form which is available and may be submitted online: https://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx

Findings: The Plan did not provide evidence demonstrating program complaints received by the County regarding Residential Adult Alcoholism or Drug Abuse Treatment Facilities, and counselor complaints are communicated to DHCS using the online complaint form.

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, ii, c

c. Provision for prompt notification to the Department when it receives information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including all of the following:
   i. Changes in the beneficiary's residence.
   ii. The death of a beneficiary.

Findings: The Plan did not provide evidence demonstrating prompt notification to DHCS regarding changes to a beneficiary's circumstances that may affect eligibility, including:

- Changes in the beneficiary's residence.
- The death of a beneficiary.

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

e. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular basis.

Findings: The Plan did not provide evidence demonstrating the application of a verification process where services represented to have been delivered by network providers are verified as being received by beneficiaries.

CD 6.2.2:
Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, ii, h

h. Provision for the Contractor's suspension of payments to a network provider for which the Department determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.

Findings: The Plan did not provide evidence demonstrating a provision for the suspension of payments to a network provider when there is a credible allegation of fraud in accordance with 42 CFR § 455.23.

CD 6.3.1

Intergovernmental Agreement Exhibit A, Attachment I, III, BB, 1

1. Service Verification. To assist DHCS in meeting its obligation under 42 CFR 455.1(a)(2), the Contractor shall establish a mechanism to verify whether services were actually furnished to beneficiaries.

Findings: The Plan did not provide evidence demonstrating an established mechanism to verify whether services were actually furnished to beneficiaries.

TECHNICAL ASSISTANCE

DHCS's County Compliance Unit Analyst will make referrals to the DHCS' CPOMB County Liaison for the training and technical assistance areas identified below:

Quality Assurance and Performance Improvement: How beneficiary education provided is consistent with practice guidelines.