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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 1, 2023

Sent via e-mail to: Georgina.Yoshioka@dbh.sbcounty.gov

Georgina Yoshioka, Interim Behavioral Health Director
San Bernardino County Behavioral Health
303 East Vanderbilt Way
San Bernardino, CA, CA 92415

SUBJECT: Annual County Compliance Section DMC-ODS Findings Report

Dear Interim Director Yoshioka:

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 Bernardino 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 Bernardino 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 Bernardino 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 5/1/2023. 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 MCBHDmonitoring@dhcs.ca.gov.

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

Sincerely,

Becky Counter
(916) 713-8567

Audits and Investigations
Contract and Enrollment Division
Behavioral Health Review Branch
County Compliance Section
1500 Capitol Ave., MS 2305
Sacramento, CA 95814
http://www.dhcs.ca.gov

Distribution:

To: Interim Director Yoshioka,

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
MCBHDMonitoring@dhcs.ca.gov, County/Provider Operations and Monitoring Branch
Catherine Smith, San Bernardino County Substance Use Disorder & Recovery Services Program Manager

COUNTY REVIEW INFORMATION

County:
San Bernardino

County Contact Name/Title:
Catherine Smith, Substance Use Disorder & Recovery Services Program Manager I

County Address:
658 E. Brier Drive, Suite 250, San Bernardino, CA 92408

County Phone Number/Email:
909-501-0803
csmith@dbh.sbcounty.gov

Date of DMC-ODS Implementation:
3/1/2018

Date of Review:
1/11/2023

Lead CCS Analyst:
Becky Counter

Assisting CCS 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 1/11/2023. The following individuals were present:

- Representing DHCS:
  Becky Counter, County Compliance Monitoring II (CCM II) Analyst
  Marcia Casado, County/Provider Operations & Monitoring Branch (CPOMB) Analyst
  Michael Bivians, County Compliance Monitoring II (CCM II) Chief
  Ayesha Smith, County Compliance Section Chief

- Representing San Bernardino County:
  Catherine Smith, San Bernardino County (SBC) Program Manager I
  Jennifer Alsina, SBC Deputy Director
  Michael Sweitzer, SBC Program Manager II
  Matty Landa, SBC Program Manager I
  Rafael Villa, SBC Program Manager I
  Jose Bernal-Sanchez, SBC Program Specialist II
  Christopher Bailey, SBC Program Specialist I
  Natalie Sanders, SBC Program Specialist I
  Robert LoPatriello, SBC Supervising Social Worker
  Gilbert Munoz, SBC Social Worker II
  Patricia Grace, SBC Supervising Automated Systems Analyst-IT
  Barbara Knutson, SBC Business Applications Manager/Information Technology (IT)
  Kim Carson, SBC Program Management II- Quality Management (QM)
  Anthony Altamirano, SBC Fiscal Administrative Supervisor I
  Anabelle Miranda-Muniz, SBC Mental Health Clinic Supervisor
  Maria Arroyo, SBC Social Worker II
  Briceida Tompkins, SBC Ethics and Compliance Coordinator
  Zakiya Otis, SBC Program Manager I

During the Entrance Conference, the following topics were discussed:

- Introductions
- Overview of review process
- San Bernardino overview of services provided

Exit Conference:

An Exit Conference was conducted via WebEx on 1/11/2023. The following individuals were present:

- Representing DHCS:
  Becky Counter, CCMII Analyst
  Marcia Casado, CPOMB Analyst
  Michael Bivians, CCM II Chief
  Ayesha Smith, County Compliance Section Chief

- Representing San Bernardino County:
  Catherine Smith, San Bernardino County (SBC) Program Manager I
  Jennifer Alsina, SBC Deputy Director
  Michael Sweitzer, SBC Program Manager II
  Matty Landa, SBC Program Manager I
  Rafael Villa, SBC Program Manager I
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  Robert LoPatriello, SBC Supervising Social Worker
  Gilbert Munoz, SBC Social Worker II
  Patricia Grace, SBC Supervising Automated Systems Analyst-IT
  Barbara Knutson, SBC Business Applications Manager/Information Technology (IT)
  Kim Carson, SBC Program Management II- Quality Management (QM)
  Anthony Altamirano, SBC Fiscal Administrative Supervisor I
  Anabelle Miranda-Muniz, SBC Mental Health Clinic Supervisor
  Maria Arroyo, SBC Social Worker II
  Briceida Tompkins, SBC Ethics and Compliance Coordinator
  Zakiya Otis, SBC Program Manager I

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 CD's
1.0	Availability of DMC-ODS Services	4
2.0	Coordination of Care Requirements	3
3.0	Quality Assurance and Performance Improvement	7
4.0	Access and Information Requirements	3
5.0	Beneficiary Rights and Protections	2
6.0	Program Integrity	0

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 1.2.2:
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 1.2.3:
Intergovernmental Agreement Exhibit A, Attachment I, II, E, 5, i, a, i-ii
i. The Contractor shall implement written policies and procedures for selection and retention of network providers and the implemented policies and procedures, at a minimum, meet the following requirements:
   a. Credentialing and re-credentialing requirements.
      i. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.
      ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers.

MHSUDS Information Notice: 18-019
CREDENTIALING POLICY 2018
For all licensed, waivered, registered and/or certified providers4, the Plan must verify and document the following items through a primary source, 5 as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by the Plan unless the Plan can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board.
1. The appropriate license and/or board certification or registration, as required for the particular provider type;
2. Evidence of graduation or completion of any required education, as required for the particular provider type;

3. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

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

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

Provider Re-credentialing
DHCS requires each Plan to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above.

42 CFR §438.214

Findings: The Plan did provide evidence to demonstrate implemented policies and procedures for the selection and retention of Plan providers however, the evidence of monitoring related to subcontracted network providers is missing the following elements:

- Evidence of graduation or completion of any required education, as required for the particular provider type;
- Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type;
- Work history;
- Hospital and clinic privileges in good standing;
- History of any suspension or curtailment of hospital and clinic privileges;
- Current Drug Enforcement Administration identification number;
- National Provider Identifier number;
- Current malpractice insurance in an adequate amount, as required for the particular provider type;

- History of liability claims against the provider;
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;
- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network. This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp;
- History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards; and
- The Plan verifies and documents credentials every three (3) years.

CD 1.2.4:
Intergovernmental Agreement Exhibit A, Attachment I, II, E, 5, i, a, i-ii

i. The Contractor shall implement written policies and procedures for selection and retention of network providers and the implemented policies and procedures, at a minimum, meet the following requirements:
   a. Credentialing and re-credentialing requirements.
      i. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.
      ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers

MHSUDS Information Notice: 18-019
Attestation
For all network providers who deliver covered services, each provider's application to contract with the Plan must include a signed and dated statement attesting to the following:

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
2. A history of loss of license or felony conviction;
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. The application's accuracy and completeness.

42 CFR §438.214

Findings: The Plan did not provide evidence to demonstrate all subcontracted network providers who deliver covered services complete the written attestation regarding their credentials. The submitted credentialing attestation forms contained the required elements, although those documents were not responded to which indicated the forms were not complete and accurate. The required elements with missing responses include:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
- A history of loss of license or felony conviction;

- A history of loss or limitation of privileges or disciplinary activity;
- A lack of present illegal drug use; and
- The application's accuracy and completeness.

and

The Plan did not provide the requested evidence to demonstrate the completion of five (5) credentialing attestations for licensed providers employed by subcontractors. The Plan provided only one (1) out of the requested five (5) completed credentialing attestations.

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 2.1.1:
Intergovernmental Agreement Exhibit A, Attachment I, III, WW, 2, i-ii, a-d

i. Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum beneficiaries, such as relationships, sexual and physical abuse, and development of parenting skills.
ii. Perinatal services shall include:
    a. Parent/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792).
    b. Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment).
    c. Education to reduce harmful effects of alcohol and drugs on the parent and fetus or the parent and infant.
    d. Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).

Findings: The Plan did not provide evidence to demonstrate perinatal services address treatment and recovery issues specific to pregnant and postpartum woman, specifically:

- Relationships, sexual and physical abuse, and development of parenting skills;
- Parent/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792);
- Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment);
- Education to reduce harmful effects of alcohol and drugs on the parent and fetus or the parent and infant; and
- Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).

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 it ensures Case Managers and Care Coordinators provide continuous support for adolescent clients entering treatment with a system that includes coordinating services with:

- Adolescent's Family.
- Mental Health.
- Physical Health Care.
- Educational Services.
- Social Services.
- Child Welfare.
- Juvenile Justice.

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 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 3.1.1:
Intergovernmental Agreement Exhibit A, Attachment I, II, SS, 1

1. The Contractor shall have a Utilization Management (UM) Program assuring that beneficiaries have appropriate access to SUD services, that services are medically necessary, that the ASAM Criteria shall be used to determine placement into the appropriate level of care, and that the interventions are appropriate for the diagnosis and level of care. The Contractor shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at an appropriate level of care following initial request or referral for all DMC-ODS services.

Findings: The Plan did not provide evidence to demonstrate the Plan has a Utilization Management (UM) Program to ensure:

- Beneficiaries have appropriate access to SUD services;
- Medical necessity has been established;
- The ASAM Criteria is used to determine placement into the appropriate level of care; and
- Interventions are appropriate for the diagnosis and level of care.

CD 3.1.4:
Intergovernmental Agreement Exhibit A, Attachment I, III, G, 3, vii

vii. Have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

Findings: The Plan did not provide evidence of practice to demonstrate the Plan and subcontracted network providers have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

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 3.2.5:
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 3.3.1:
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 Admissions report is not in compliance.

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.

and

The Plan did not provide evidence of practice 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 4.3.2:
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 VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.).
- Age Discrimination in Employment Act (29 CFR Part 1625).
- 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:

- Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
- Title 9, Division 4, Chapter 8, commencing with Section 10800.
- No state or Federal funds are used by the Contractor, or its subcontractors, for sectarian worship, instruction, and/or proselytization.
- No state funds are used by the Contractor, or its subcontractors, to provide direct, immediate, or substantial support to any religious activity.
- 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 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.
- 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:

- No 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 compliance with the inclusion of all protected categories of grievances related to any action prohibited by or out of compliance with federal or state nondiscrimination law based on the following characteristics, specifically:

- Religion
- Ancestry
- National Origin
- Ethnic Group Identification
- Genetic Information
- Marital Status
- Gender and
- Sexual Orientation.

TECHNICAL ASSISTANCE

San Bernardino County did not request Technical Assistance in FY 22-23.