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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

June 3, 2019

Sent via e-mail to: Karen.Larsen@YoloCounty.org

Karen Larsen, LMFT, Mental Health Director
Yolo County HHSA
137 N. Cottonwood Street, Suite 2500
Woodland, CA 95695

SUBJECT: Annual County Performance Unit Report

Dear Director Larsen:

The Department of Health Care Services (DHCS) is responsible for monitoring compliance to requirements of the Substance Abuse Block Grant (SABG) and operated by Yolo County.

The County Performance Unit (CPU) within the Substance Use Disorder Program, Policy, and Fiscal Division (SUDPPFD) 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 Yolo County's 2018-19 SABG compliance review. The report identifies deficiencies, required corrective actions, advisory recommendations, and referrals for technical assistance.

Yolo County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 7/3/2019. Please follow the enclosed instructions when completing the CAP. Supporting CAP documentation may be e-mailed to the CPU analyst or mailed to the address listed below.

If you have any questions regarding this report or need assistance, please contact me.

Sincerely,

BL Counter

Becky Counter
(916) 713-8567
becky.counter@dhcs.ca.gov

Substance Use Disorder
Program, Policy and Fiscal Division
County Performance Unit
P.O. Box 997413, MS 2627
Sacramento, CA 95814
http://www.dhcs.ca.gov

Distribution:

To: Director Larsen

CC: Tracie Walker, Performance & Integrity Branch Chief
Sandi Snelgrove, Prevention and Family Services Section Chief.
Janet Rudnick, Utilization Review Section Chief
Cynthia Hudgins, Quality Monitoring Section Chief
Susan Jones, County Performance Supervisor
Tianna Hammock, Drug Medi-Cal Monitoring Unit I Supervisor
Stephanie Quok, Drug Medi-Cal Monitoring Unit II Supervisor
Tiffiny Stover, Postservice Postpayment Unit I Supervisor
Eric Painter, Postservice Postpayment Unit II Supervisor
Jessica Fielding, Office of Women, Perinatal and Youth Services Supervisor
Patricia Gulfam, Prevention Quality Assurance and Support Unit Supervisor
Ian Evans, LMFT, Yolo County AOD Administrator

Lead CPU Analyst: Becky Counter **Assisting CPU Analyst(s):** Michael Bivians	**Date of Review:** 5/8/2019 - 5/9/2019
County: Yolo County	**County Address:** 137 N. Cottonwood St. Woodland, CA 95695
County Contact Name/Title: Ian Evans, LMFT AOD Administrator	**County Phone Number/Email:** (530) 666-8297 Ian.evans@yolocounty.org
Report Prepared by: Becky Counter	**Report Approved by:** Susan Jones

REVIEW SCOPE

I. Regulations:
   a. 45 CFR; Part 96; Subpart L; §96.121 through 96.137: Substance Abuse Prevention and Treatment Block Grant
   b. 42 USC, Section 300x-21 through 300x-66: Substance Abuse Prevention and Treatment Block
   c. HSC, Division 10.5, Section 11750 – 11970: State Department of Health Care

II. Program Requirements:
   a. State Fiscal Year (SFY) 2018-19 State County Contract, herein referred to as State County Contract
   b. State of California *Youth Treatment Guidelines Revised August 2002*
   c. DHCS *Perinatal Services Network Guidelines SFY 2016-17*
   d. National Culturally and Linguistically Appropriate Services (CLAS)
   e. Mental Health and Substance Use Disorders Services (MHSUDS) Information Notices

ENTRANCE AND EXIT CONFERENCE SUMMARIES

Entrance Conference:
An entrance conference was conducted at 137 N. Cottonwood St., Woodland, CA on 5/8/2019. The following individuals were present:

- Representing DHCS:
  Becky Counter, AGPA
  Mike Bivians, AGPA
  Tiana Hammock, SSM1

- Representing Yolo County:
  Samantha Fussleman, Deputy MH Director
  Helen Ng, QM Analyst
  Sajana Budhamolgi, QM Analyst
  Ian Evans, AOD Administrator
  Ann Margaret Armas, MHSA Clinician
  Fabian Valle, QM Analyst
  Pam Sidhu, Senior Admin Analyst
  Amy Leino, Supervising Clinician
  Katherine Barrett, BH Compliance Officer

During the Entrance Conference the following topics were discussed:

- Introductions
- DHCS provided an overview of the review
- County provided an overview of the County and the services available

Exit Conference:
An exit conference was conducted at 137 N. Cottonwood St., Woodland, CA on 5/9/2019. The following individuals were present:

- Representing DHCS:
  Becky Counter, AGPA
  Mike Bivians, AGPA

- Representing Yolo County:
  Ian Evans, AOD Administrator
  Samantha Fussleman, Deputy MH Director
  Sajana Budhalmolgi, QM Analyst
  Helen Ng, QM Analyst
  Amy Leino, Supervising Clinician
  Ann Margaret Armas, MHSA Clinician
  Fabian Valle, QM Analyst
  Pam Sidhu, Senior Admin Analyst

During the Exit Conference the following topics were discussed:

- Reviewed all follow-up items for both the County and DHCS.
- DHCS outlined the next steps and when the County should expect their final report.

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	0
2.0 SABG Monitoring	0
3.0 Perinatal	0
4.0 Adolescent/Youth Treatment	0
5.0 Primary Prevention	0
6.0 Cultural Competence	0
7.0 CalOMS and DATAR	2
8.0 Privacy and Information Security	0

CORRECTIVE ACTION PLAN

Pursuant to the State County Contract, Exhibit A, Attachment I A1, Part I, Section 3, 7, (a-d) each compliance deficiency (CD) identified must be addressed via a Corrective Action Plan (CAP). The CAP is due within thirty (30) calendar days of the date of this monitoring report. Advisory recommendations are not required to be addressed in the CAP.

Please provide the following within the completed 2018-19 CAP.

a) A statement of the compliance deficiency (CD).
b) A list of action steps to be taken to correct the CD.
c) A date of completion for each CD.
d) Who will be responsible for correction and ongoing compliance.

The CPU analyst will monitor progress of the CAP completion.

7.0 CALIFORNIA OUTCOMES MEASUREMENT SYSTEM TREATMENT (CalOMS Tx) AND DRUG AND ALCOHOL TREATMENT ACCESS REPORT (DATAR)

The following deficiencies in CalOMS and DATAR regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 7.34.a:

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, B, 3, 5, 6

(3) 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.

(5) Contractor shall submit CalOMS-Tx admissions, 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.

(6) Contractor shall comply with the CalOMsTx 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.

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, D, 6

Contractor shall comply with the treatment and prevention data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may result in withholding SABG funds.

Finding: The County's open provider report is not current.

CD 7.34.b:

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, B, 3, 5, 6

(3) 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.

(5) Contractor shall submit CalOMS-Tx admissions, 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.

(6) Contractor shall comply with the CalOMsTx 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.

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, D, 6

Contractor shall comply with the treatment and prevention data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may result in withholding SABG funds.

Finding: The County's open admission report is not current.

9.0 TECHNICAL ASSISTANCE

Yolo County did not request technical assistance during this fiscal year.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

June 3, 2019

Sent via e-mail to: karen.larsen@yolocounty.org

Karen Larsen, LMFT, Mental Health Director
Yolo County HHSA
137 N. Cottonwood Street Suite 2500
Woodland, CA 95695

SUBJECT: Annual County Performance Unit Report

Dear Select Title:

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 Yolo County.

The County Performance Unit (CPU) within the Substance Use Disorder Program, Policy, and Fiscal Division (SUDPPFD) 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 Yolo County's 2018-19 DMC-ODS compliance review. The report identifies deficiencies, required corrective actions, new requirements, advisory recommendations, and referrals for technical assistance.

Yolo County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 7/3/2019. Please follow the enclosed instructions when completing the CAP. Supporting CAP documentation may be e-mailed to the CPU analyst or mailed to the address listed below.

If you have any questions regarding this report or need assistance, please contact me.

Sincerely,

Michael Bivians

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

Distribution:

To: Director Larsen

CC: Don Braeger, Substance Use Disorders - Program, Policy and Fiscal Division Chief
Tracie Walker, Performance & Integrity Branch Chief
Sandi Snelgrove, Prevention and Family Services Section Chief.
Cynthia Hudgins, Quality Monitoring Section Chief
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Jessica Fielding, Office of Women, Perinatal and Youth Services Supervisor
Patricia Gulfam, Prevention Quality Assurance and Support Unit Supervisor
Ian Evans, LMFT, Yolo County AOD Administrator

Lead CPU Analyst: Becky Counter **Assisting CPU Analyst(s):** Michael Bivians	**Date of Review:** 5/8/2019 - 5/9/2019 **Date of DMC-ODS Implementation:** 6/30/2018
County: Yolo County	**County Address:** 137 N. Cottonwood Street Woodland, CA 95695
County Contact Name/Title: Ian Evans, LMFT, AOD Administrator	**County Phone Number/Email:** 530-666-8297 ian.evans@yolocounty.org
Report Prepared by: Michael Bivians	**Report Approved by:** Susan Jones

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. 42 CFR; Chapter IV, Subchapter C, Part 438; §438.1 through 438.930: Managed Care

II. Program Requirements:
   a. State Fiscal Year (SFY) 2018-19 Intergovernmental Agreement (IA)
   b. Mental Health and Substance Use Disorders Services (MHSUDS) Information Notices

ENTRANCE AND EXIT CONFERENCE SUMMARIES

Entrance Conference:
An entrance conference was conducted at 137 N. Cottonwood St., Woodland, CA 95695 on 5/8/2019. The following individuals were present:

- Representing DHCS:
  Becky Counter, Associate Governmental Program Analyst (AGPA)
  Mike Bivians, AGPA
  Tiana Hammock, SSM1

- Representing Yolo County:
  Samantha Fussleman, Deputy MH Director
  Helen Ng, QM Analyst
  Sajana Budhamolgi, QM Analyst
  Ian Evans, AOD Administrator
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An exit conference was conducted at 137 N. Cottonwood St., Woodland, CA 95695 on 5/9/2019. The following individuals were present:

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  Becky Counter, AGPA
  Mike Bivians, AGPA

- Representing Yolo County:
  Ian Evans, AOD Administrator
  Samantha Fussleman, Deputy MH Director
  Sajana Budhalmolgi, QM Analyst
  Helen Ng, QM Analyst
  Amy Leino, Supervising Clinician
  Ann Margaret Armas, MHSA Clinician
  Fabian Valle, QM Analyst
  Pam Sidhu, Senior Admin Analyst

During the Exit Conference the following topics were discussed:

- Reviewed all follow-up items for both the County and DHCS.
- DHCS outlined the next steps and when the County should expect their final report.

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD) AND NEW REQUIREMENTS (NR)

Section:	Number of CD's and NR's:
1.0 Administration	0
2.0 Member Services	1
3.0 Service Provisions	0
4.0 Access	2
5.0 Continuity and Coordination of Care	0
6.0 Grievance, Appeal, and Fair Hearing Process	0
7.0 Quality	3
8.0 Program Integrity	1

CORRECTIVE ACTION PLAN

Pursuant to the Intergovernmental Agreement, Exhibit A, Attachment I, Part II, Section EE, 2 each compliance deficiency (CD) identified must be addressed via a Corrective Action Plan (CAP). The CAP is due within thirty (30) calendar days of the date of this monitoring report. Advisory recommendations are not required to be addressed in the CAP.

Please provide the following within the completed 2018-19 CAP:

a) A statement of the compliance deficiency (CD).
b) A list of action steps to be taken to correct the CD.
c) A date of completion for each CD.
d) Who will be responsible for correction and ongoing compliance.

The CPU analyst will monitor progress of the CAP completion.

2.0 MEMBER SERVICES

The following deficiencies in the member services requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 2.10:

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 xvii, a.

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

Finding: The Plan did not provide a current and finalized copy of the Plan's beneficiary handbook in all County threshold languages. The beneficiary handbook was missing the follow required criteria:

- Who Do I Contact If I'm Having Suicidal Thoughts?
- Information for Members Who Need Materials in a Different Language
- Who Do I Contact If I Feel That I Was Discriminated Against?
- Where Can I Get Specialty Mental Health Services?
- Does Medi-Cal Cover Transportation?
- Transition Of Care Request

4.0 ACCESS

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

COMPLIANCE DEFICIENCIES:

CD 4.26:

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 5. a. i – ii.

i. The Contractor shall implement written policies and procedures for selection and retention of network providers and that those 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.
      ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers.

MHSUDS Information Notice: 18-019

Effective immediately, Plans must implement and maintain written policies and procedures for the initial credentialing and re-credentialing of their providers in accordance with the policy outlined in this IN…

Credentialing Policy

For all licensed, waivered, registered and/or certified providers, the Plan must verify and document the following items through a primary source, 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. The Plan must require each provider to submit any updated information needed to complete the re-credentialing process, as well as a new signed attestation. In addition to the initial credentialing requirements, re-credentialing should include documentation that the Plan has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, beneficiary grievances, and medical record reviews.

Finding: The Plan's policy does not include that the following items are verified through a primary source:

- Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type.

The Plan's policy does not include that the following items may be verified through a non-primary source:

- Work history;
- Hospital and clinic privileges in good standing;
- History of any suspension;
- Current Drug Enforcement Administration identification number;
- Current malpractice insurance…;
- History of liability claims against the provider;
- Provider information, if any, entered in the National Practitioner Data Bank;
- History of sanctions…;
- Suspended and Ineligible Provider List …; and
- History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

CD 4.27:
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 the beneficiary receives from community and social support providers.

Finding: The Plan's attestation does not contain the following requirements:

- 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; and
- A lack of present illegal drug use.

7.0 QUALITY

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

COMPLIANCE DEFICIENCIES:

CD 7.46:

Intergovernmental Agreement Exhibit A, Attachment I, III, LL, 4, i – ix.

4. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:
    i. Timeliness of first initial contact to face-to-face appointment.
    ii. Frequency of follow-up appointments in accordance with individualized treatment plans.
    iii. Timeliness of services of the first dose of NTP services.
    iv. Access to after-hours care.
    v. Responsiveness of the beneficiary access line.
    vi. Strategies to reduce avoidable hospitalizations.
    vii. Coordination of physical and mental health services with waiver services at the provider level.
    viii. Assessment of the beneficiaries' experiences.
    ix. Telephone access line and services in the prevalent non-English languages.

Finding: The Plan's Quality Improvement (QI) Plan does not include the following requirements:

- Timeliness of first initial contact to face-to-face appointment;
- Frequency of follow-up appointments in accordance with individualized treatment plans;
- Timeliness of services of the first dose of NTP services;
- Access to after-hours care; and
- Strategies to reduce avoidable hospitalizations.

CD 7.49:

Intergovernmental Agreement Exhibit A, Attachment I, III, LL, 10-11.

10. The Contractor shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in 42 CFR 438.240(b)(1) and (d). Performance improvement projects shall focus on a clinical area, as well as one non-clinical area.
11. PIPs shall:
    i. Measure performance using required quality indicators.
    ii. Implement system interventions to achieve improvement in quality.
    iii. Evaluate the effectiveness of interventions.
    iv. Plan and initiate activities for increasing or sustaining improvement.

Finding: The Plan does not currently have two active Performance Improvement Projects (PIP).

- Focus on a clinical area; and
- Focus on a non-clinical area.

CD 7.50:

Intergovernmental Agreement Exhibit A, Attachment I, III, FF, 3, i, c-f.

i. The CalOMS-Tx business rules and requirements are:
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.

a. 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.
b. 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.
d. 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.

Intergovernmental Agreement Exhibit A, Attachment I, III, AA, 2, iv.

2. Each subcontract shall:
iv. Ensure that the Contractor monitor the subcontractor's performance on an ongoing basis and subject it to an annual onsite review, consistent with statutes, regulations, and Article III.PP.

Finding: The following CalOMS Tx report(s) are non-compliant:

- Open Admissions Report
- Open Providers Report

8.0 PROGRAM INTEGRITY

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

COMPLIANCE DEFICIENCIES:

CD 8.58:

Intergovernmental Agreement Exhibit A, Attachment I, III. PP, 6, i – ii.

i. The substance use disorder 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 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, 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 substance use disorder medical director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however, the substance use disorder medical director shall remain responsible for ensuring all delegated duties are properly performed..

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 written roles and responsibilities, and code of conduct did not meet the following requirement(s):

- Signed and dated by a provider representative