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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

February 20, 2019

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 County Performance Unit 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 (IA) operated by Napa 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 Napa County's 2018-19 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 deficiency noted to becky.counter@dhcs.ca.gov by 3/20/2019. 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,

Rotna Simmons
(916) 713-8573
rotna.simmons@dhcs.ca.gov

Distribution:

To: Director Yasumoto:

CC: Don Braeger, Substance Use Disorders - Program, Policy and Fiscal Division, Chief
Tracie Walker, Performance & Integrity Branch, Chief
Sandi Snelgrove, Policy and Prevention Branch, Chief
Cynthia Hudgins, Quality Monitoring Section, Chief
Janet Rudnick, Utilization Review Section, Chief
Susan Jones, County Performance Unit, 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
Vanessa Machado, Policy and Prevention Branch, Office Technician
Karen McElroy, Napa County, Staff Services Analyst II

Lead CPU Analyst: Rotna Simmons **Assisting CPU Analyst(s):** Becky Counter Austin Trujillo Jamari Robinson	**Date of Review:** 11/13/2018 - 11/14/2018
County: Napa County	**County Address:** 2751 Napa Valley Corporate Dr. Napa County CA 94559
County Contact Name/Title: Karen McElroy, Staff Services Analyst II	**County Phone Number/Email:** 707-253-4267 karen.mcelroy@countyofnapa.org
Report Prepared by: Rotna Simmons	**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 2751 Napa Valley Corporate Dr. Napa CA on 11/13/2018. The following individuals were present:

- Representing DHCS:
  Rotna Simmons, AGPA
  Becky Counter, AGPA
  Austin Trujillo, AGPA
  Jamari Robinson, AGPA

- Representing Napa County:
  Jacqueline Connors, Deputy Director
  Bill Carter, QM Compliance Officer
  Karen McElroy, SSA II
  Teresa Salvatore, Assistant Deputy Director
  Rose Hardcastle, Chief Financial Officer
  Karina Gallegos-Ruiz, SSA II
  Kimberly Drummer, Deputy CFO

During the Entrance Conference the following topics were discussed:

- DHCS gave an overview of the monitoring purpose and process
- Reviewed the site agenda

Exit Conference:
An exit conference was conducted at 2751 Napa Valley Corporate Dr. Napa CA on 11/14/2018. The following individuals were present:

- Representing DHCS:
  Rotna Simmons, AGPA
  Becky Counter, AGPA
  Austin Trujillo, AGPA
  Jamari Robinson, AGPA

- Representing Napa County:
  Jacqueline Connors, Deputy Director
  Teresa Salvatore, Assistant Deputy
  Karen McElroy, SSA II

During the Exit Conference the following topics were discussed:

- DHCS reviewed compliance deficiencies
- Discussed recommendations

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	1
2.0 Member Services	1
3.0 Service Provisions	1
4.0 Access	4
5.0 Continuity and Coordination of Care	0
6.0 Grievance, Appeal, and Fair Hearing Process	0
7.0 Quality	0
8.0 Program Integrity	0

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.

1.0 ADMINISTRATION

A review of the administrative trainings, policies, and procedures was conducted to ensure compliance with applicable regulations and standards. The following deficiencies in administration requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 1.5:

Intergovernmental Agreement Exhibit A, Attachment I, III, GG, 3, ii. a.

ii. The Contractor shall require subcontractors to be trained in the ASAM Criteria prior to providing services.
   a. The Contractor shall ensure that, at a minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”. A third module entitled, “Introduction to The ASAM Criteria” is recommended for all county and provider staff participating in the Waiver. With assistance from the state, counties will facilitate ASAM provider trainings.

Finding: The Plan did not demonstrate that all providers and staff conducting ASAM assessments have completed the two e-Trainings annually.

2.0 MEMBER SERVICES

The following deficiencies in the Member Services requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 2.14

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, xv, a-c.

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
   viiii. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.
b. The Contractor shall include the following provider types covered under this Agreement in the provider directory:
   i. Physicians, including specialists
   ii. Hospitals
   iii. Pharmacies
   iv. Behavioral health providers
c. Information included in a paper provider directory shall be updated at least monthly and electronic provider directories shall be updated no later than 30 calendar days after the Contractor receives updated provider information.

MHSUDS Information Notice: 18-020

Provider Directory Content-

Each Plan's provider directory must make available in electronic form, and paper form upon request, the following information for all network providers, including each licensed, waivered, or registered mental health provider and licensed substance use disorder services provider employed by the Plan, each provider organization or individual practitioner contracting with the Plan, and each licensed, waivered, or registered mental health provider and licensed substance use disorder services provider employed by a provider organization to deliver Medi-Cal services:

- The provider's name and group affiliation, if any;
- Provider's business address(es) (e.g., physical location of the clinic or office);
- Telephone number(s);
- Email address(es), as appropriate;
- Website URL, as appropriate;
- Specialty, in terms of training, experience and specialization, including board certification (if any);

- Services / modalities provided, including information about populations served (i.e., perinatal, children/youth, adults);
- Whether the provider accepts new beneficiaries;
- The provider's cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender);
- The provider's linguistic capabilities including languages offered (e.g., Spanish, Tagalog, American Sign Language) by the provider or a skilled medical interpreter at the provider's office; and,
- Whether the provider's office / facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.
- In addition to the information listed above, 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 provider directory currently posted on the Plan's website is dated 2017 and the copy of the provider directory submitted electronically to DHCS did not have any dates indicating reviews or revisions had been completed as required. The State was unable to verify the Directory was current. Additionally, the provider directory was missing the following required element(s):

- Type of practitioner, as appropriate
- National Provider Identifier number
- California license number and type of license
- An indication of whether the provider has completed cultural competence training

3.0 SERVICE PROVISION

The following deficiencies in Service Provision requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 3.17:

Intergovernmental Agreement Exhibit A, Attachment I, III, C, 2.

2. The Contractor shall deliver the DMC-ODS Covered Services within a continuum of care as defined in the ASAM criteria.

Intergovernmental Agreement Exhibit A, Attachment I, III, C, 3,i-ix.

3. Mandatory DMC-ODS Covered Services include:
    i. Withdrawal Management (minimum one level);
    ii. Intensive Outpatient;
    iii Outpatient;
    iv. Opioid (Narcotic) Treatment Programs;
    v. Recovery Services;
    vi. Case Management;
    vii. Physician Consultation;
    viii. Perinatal Residential Substance Abuse Services (excluding room and board);
    ix. Non-perinatal Residential Substance Abuse Services (excluding room and board);

Intergovernmental Agreement Exhibit A, Attachment I, III, H, 1, v.

1. The Contractor shall implement residential treatment program standards that comply with the authorization of services requirements set forth in Article II.E.4. and shall:
    v. Ensure that at least one ASAM level of Residential Treatment Services is available to beneficiaries in the first year of implementation;

Finding: The Plan does not provide the following required levels of care through their network:

- Opioid (Narcotic) Treatment Programs;
- Perinatal Residential Substance Abuse Services;
- Non-perinatal Residential Substance Abuse Services

4.0 ACCESS

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

COMPLIANCE DEFICIENCIES:

CD 4.24:

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 5, a-d.

5. 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.
    b. Nondiscrimination.
        i. The Contractor's network provider selection policies and procedures, consistent with 42 CFR §438.12, shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
    c. Excluded providers.
        i. The Contractor shall not employ or subcontract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.
    d. Additional Department requirements.
        i. The Contractor shall comply with any additional requirements established by the Department.

Finding: The Plan does not have policies and procedures to address selection and retention of network providers.

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, 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.

Finding: The Plan's policies do not include the requirements listed below are verified through a non-primary source:

- Hospital and clinic privileges in good standing
- History of any suspension
- Current Drug Enforcement Administration identification number
- National Provider Identifier 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
- 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: Evidence of written attestation of credentialing requirements was not found.

CD 4.29:

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 1, ii, a.

ii. The Contractor shall, consistent with the scope of its contracted services, meet the following requirements:
   a. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Agreement for all beneficiaries, including those with limited English proficiency or physical or mental disabilities

Intergovernmental Agreement Exhibit A, Attachment I, III, E, 1, i-iii.

E. Availability of Services

1. In addition to the availability of services requirements set forth in Article II,E,1 of this Agreement, the Contractor shall:
   i. Consider the numbers and types (in terms of training, experience and specialization) of providers required to ensure the availability and accessibility of medically necessary services;
   ii. Maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide its beneficiaries with adequate access to all services covered under this Agreement.
   iii. In establishing and monitoring the network, document the following:
      a. The anticipated number of Medi-Cal eligible beneficiaries.
      b. The expected utilization of services, taking into account the characteristics and SUD treatment needs of beneficiaries.
      c. The expected number and types of providers in terms of training and experience needed to meet expected utilization.
      d. The numbers of network providers who are not accepting new beneficiaries.
      e. The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disabled beneficiaries.

AB 205, Sec. 7, 14197(c)(4)(A)(i-iii)

(4) (A) For outpatient substance use disorder services other than opioid treatment programs, as follows:
(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
(iii) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

AB 205, Sec. 7, 14197(c)(4)(B)(i-iv)
(B) For opioid treatment programs, as follows:
(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
(iii) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
(iv) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

AB 205, Sec. 7, 14197(e)(1-4)
(e) (1) The Department, upon request of a Medi-Cal managed care plan, may allow alternative access standards for the time and distance standards established under this section if either of the following occur:
(A) The requesting Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet the applicable standard.
(B) The department determines that the requesting Medi-Cal managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
(2) If a Medi-Cal managed care plan cannot meet the time and distance standards set forth in this section, the Medi-Cal managed care plan shall submit a request for alternative access standards to the department, in the form and manner specified by the department. A request may be submitted at the same time as the Medi-Cal managed care plan submits its annual demonstration of compliance with time and distance standards, if known at that time.
(3) A request for alternative access standards shall be approved or denied on a ZIP Code and provider type, including specialty type, basis by the department within 90 days of submission of the request. The Medi-Cal managed care plan shall also include a description of the reasons justifying the alternative access standards based on those facts and circumstances. The department may stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Medi-Cal

managed care plan requesting the alternative access standards. Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume at the same point in time it was previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information. If the department rejects the Medi-Cal managed care plan's proposal, the department shall inform the Medi-Cal managed care plan of the department's reason for rejecting the proposal. The department shall post any approved alternative access standards on its Internet Web site.

(4) The department may allow for the use of clinically appropriate telecommunications technology as a means of determining annual compliance with the time and distance standards established pursuant to this section or approving alternative access to care, including telehealth consistent with the requirements of Section 2290.5 of the Business and Professions Code, e-visits, or other evolving and innovative technological solutions that are used to provide care from a distance.

Finding: Evidence of the Plan monitoring network providers' time and distance standards was not found.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

February 20, 2019

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 County Performance Unit Report

Dear Director Yasumoto:

The Department of Health Care Services (DHCS) is responsible for monitoring compliance to requirements of the Substance Abuse Block Grant (SABG) Contract operated by Napa 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 Napa County's 2018-19 SABG compliance review. The report identifies deficiencies, required corrective actions, advisory recommendations, and referrals for technical assistance.

Napa County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 3/20/2019. 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,

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

Distribution:

To: Director Yasumoto

CC: Tracie Walker, Performance & Integrity Branch, Chief
Sandi Snelgrove, Policy and Prevention, Chief
Janet Rudnick, Utilization Review, Section Chief
Cynthia Hudgins, Quality Monitoring, Section Chief
Susan Jones, County Performance Unit, Supervisor
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Tiffiny Stover, Postservice Postpayment Unit I, Supervisor
Eric Painter, Postservice Postpayment Unit II, Supervisor
Vanessa Machado, Policy and Prevention Branch, Office Technician
Karen McElroy, Napa County SSA II

Lead CPU Analyst: Becky Counter **Assisting CPU Analyst(s):** Jamari Robinson	**Date of Review:** 11/13/2018 - 11/14/2018
County: Napa	**County Address:** 2751 Napa Valley Corporate Dr. Napa, CA 94558
County Contact Name/Title: Karen McElroy	**County Phone Number/Email:** 707 253-4267 Karen.mcelroy@countyofnapa.org
Report Prepared by: Becky Counter	**Report Approved by:** Susan Jones

REVIEW SCOPE

I. Regulations:
   a. 22 CCR § 51341.1 – Drug Medi-Cal Substance Use Disorder Services
   b. 45 CFR; Part 96; Subpart L; §96.121 through 96.137: Substance Abuse Prevention and Treatment Block Grant
   c. 42 USC, Section 300x-21 through 300x-66: Substance Abuse Prevention and Treatment Block
   d. 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 2751 Napa Valley Corporate Dr. on 11/13/2018. The following individuals were present:

- Representing DHCS:
  Becky Counter, AGPA
  Rotna Simmons, AGPA
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  Jamari Robinson, AGPA

- Representing Napa County:
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  Teresa Salvatore, Assistant Deputy Director
  Rose Hardcastle, Chief Financial Officer
  Karina Gallegos-Ruiz, SSA II
  Kimberly Drummer, Deputy CFO

During the Entrance Conference the following topics were discussed:

- DHCS gave an overview of the monitoring purpose and process
- Reviewed the site review agenda

Exit Conference:
An exit conference was conducted at 2751 Napa Valley Corporate Dr. on 11/14/2018. The following individuals were present:

- Representing DHCS:
  Becky Counter, AGPA
  Rotna Simmons, AGPA
  Austin Trujillo, AGPA
  Jamari Robinson, AGPA

- Representing Napa County:
  Jacqueline Connors, Deputy Director
  Teresa Salvatore, Assistant Deputy
  Karen McElroy, SSA II

During the Exit Conference the following topics were discussed:

- DHCS reviewed compliance deficiencies
- Discussed recommendations

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	1
2.0 SABG Monitoring	1
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	0
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.

1.0 ADMINISTRATION

A review of the County's Organizational Chart, subcontracted contracts, and policies and procedures was conducted to ensure compliance with applicable regulations and standards. The following deficiencies in regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 1.5:

SABG State-County Contract Exhibit A, Attachment I AI, Part II, B
Hatch Act: Contractor agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

SABG State-County Contract Exhibit A, Attachment I AI, Part II, Y
Subcontract Provisions: Contractor shall include all of the foregoing Part II general provisions in all of its subcontracts.

Finding: The County did not demonstrate County and subcontractor staff compliance with the Hatch Act.

2.0 SABG MONITORING

The following deficiencies in the SABG monitoring requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 2.15:

SABG State-County Contract Exhibit A, Attachment I A1, Part I, Section 3, A, 1 (a-e)
Contractor's performance under this Exhibit A, Attachment I, Part I, shall be monitored by DHCS during the term of this Contract. Monitoring criteria shall include, but not be limited to:
a) Whether the quantity of work or services being performed conforms to Exhibit B.
b) Whether the Contractor has established and is monitoring appropriate quality standards.
c) Whether the Contractor is abiding by all the terms and requirements of this Contract.
d) Whether the Contractor is abiding by the terms of the Perinatal Services Network Practice Guidelines (Document 1G).
e) Whether the Contractor conducted annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of its monitoring and audit reports to DHCS within two weeks of issuance. Reports shall be sent by secure, encrypted email to:

SUDCountyReports@dhcs.ca.gov or Substance Use Disorder-Program, Policy, and Fiscal Division
Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2627
Sacramento, CA 95899-7413

Finding: The County did not submit one of their SABG monitoring reports for SFY 17-18 to DHCS within two weeks of report issuance.

10.0 TECHNICAL ASSISTANCE

The County did not request Technical Assistance during this fiscal year.