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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

April 19, 2019

Sent via e-mail to: sgilman@smcgov.org

Scott Gilman, Director
San Mateo County Behavioral Health and Recovery Services
310 Harbor Blvd., Building E
Belmont, CA 94002

SUBJECT: Annual County Performance Unit Report

Dear Director Gilman:

The Department of Health Care Services (DHCS) is responsible for monitoring compliance to the requirements of the DMC-ODS Waiver and the terms of the Intergovernmental Agreement operated by San Mateo 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 Intergovernmental Agreement (IA) 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 Mateo County's 2018-19 Drug Medi-Cal Organized Delivery System (DMC-ODS) IA compliance review. The report identifies deficiencies, required corrective actions, new requirements, advisory recommendations, and referrals for technical assistance.

San Mateo County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by May 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,

Jennifer Johnson
(916) 713-8635
jennifer.johnson@dhcs.ca.gov

Distribution:

To: Director, Scott Gilman

CC: Don Braeger, Substance Use Disorders - Program, Policy and Fiscal Division Chief
Tracie Walker, Performance & Integrity Branch Chief
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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
Jessica Fielding, Office of Women, Perinatal and Youth Services, Unit Supervisor
Vanessa Machado, Policy and Prevention Branch Office Technician
Clara Boyden, Alcohol and Other Drug Program Manager

Lead CPU Analyst: Jennifer Johnson **Assisting CPU Analyst(s):** Trang Huynh Jamari Robinson Jessica Jenkins	**Date of Review:** 1/8/2019 - 1/11/2019 **Date of Implementation:** 2/1/2017
County: San Mateo	**County Address:** 310 Harbor Blvd., Building E, Belmont, CA 94002
County Contact Name/Title: Clara Boyden, Alcohol and Other Drug Programs Manager	**County Phone Number/Email:** 650-802-5101 CBoyden@smcgov.org
Report Prepared by: Jennifer Johnson	**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 310 Harbor Blvd., Building E, Belmont, CA 94002 on 1/8/2019.The following individuals were present:

- Representing DHCS:
  Jennifer Johnson, Associate Governmental Program Analyst (AGPA)
  Trang Huynh, AGPA
  Jamari Robinson, AGPA
  Jessica Jenkins, AGPA

- Representing San Mateo County:
  Diana Hill, HSM1
  Sheryl Uyan, WOC Supervisor
  Christine O'Kelly, BHRS Supervisor
  Clara Boyden, SMC BHRS
  Ingall Bull, QM Manager
  Denise Mosely, BHRS Analyst

During the Entrance Conference the following topics were discussed:
- Overview of the monitoring purpose and process
- The site review agenda

Exit Conference:
An exit conference was conducted at 310 Harbor Blvd., Building E, Belmont, CA 94002 on 1/11/2019. The following individuals were present:

- Representing DHCS:
  Jennifer Johnson, AGPA
  Trang Huynh, AGPA
  Jamari Robinson, AGPA
  Jessica Jenkins, AGPA

- Representing San Mateo County:
  Diana Hill, HSM 1
  Christine O'Kelly, BHRS Supervisor
  Clara Boyden, SMC BHRS
  Ingall Bull, QM Manager
  Denise Mosely, BHRS Analyst

During the Exit Conference the following topics were discussed:
- Compliance deficiencies
- Recommendations

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

Section:	Number of CD's and NR's:
1.0 Administration	1
2.0 Member Services	3
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	1
7.0 Quality	2
8.0 Program Integrity	2

PREVIOUS CAPs

During the SFY 2018-19 review, the following CAP with CD were discussed and are still outstanding.

2017-18:

CD 2.17 Finding: The provider directory, with an original implementation date of 1/19/19, is missing the following required element(s):

- National Provider Identifier number;
- California license number and type of license; and,
- An indication of whether the provider has completed cultural competence training.

Plan's response: The Plan will continue to work with DHCS to make the required changes to their Provider Directory. The Plan's new expected date of completion is 7/1/19.

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) and new requirement (NR).
b) A list of action steps to be taken to correct the CD/NR.
c) A date of completion for each CD/NR.
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 1.2:

Intergovernmental Agreement Exhibit A, Attachment I, III, A, 1, iv.

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

Finding: The Plan did not demonstrate that they ensure professional staff (LPHAs) have five (5) hours of continuing education in addiction medicine annually.

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, xiv, a.

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

Intergovernmental Agreement Exhibit A, Attachment I, 14, E

E. The Contractor shall ensure that the general program literature it uses to assist beneficiaries in accessing services including, but not limited to, the booklet required by 42 CFR 438.10, materials explaining the beneficiary problem resolution and fair hearing processes, and SUD education materials used by the Contractor, are available in the threshold languages of the Contractor's county in compliance with 42 CFR 438.10(c)(3).

Finding: The Beneficiary handbook did not address "Transition of Care" and was not translated into the required Threshold Language, which is Spanish.

CD 2.12:

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

Information Requirements (42 CFR §438.10).

iv. Beneficiary information required in this section may not be provided electronically by the Contractor unless all of the following are met:
    a. The format is readily accessible;
    b. The information is placed in a location on the Department or the Contractor's website that is prominent and readily accessible;
    c. The information is provided in an electronic form which can be electronically retained and printed;
    d. The information is consistent with the content and language requirements of this section; and
    e. The beneficiary is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, xiv. d, i-iv.

d. The beneficiary handbook will be considered to be provided if the Contractor:
    i. Mails a printed copy of the information to the beneficiary's mailing address;
    ii. Provides the information by email after obtaining the beneficiary's agreement to receive the information by email;

iii. Posts the information on the Contractor's website and advises the beneficiary in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
iv. Provides the information by any other method that can reasonably be expected to result in the beneficiary receiving that information.

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, xiv, b.

b. The Contractor shall provide each beneficiary a beneficiary handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves as the summary of benefits and coverage described in 45 CFR § 147.200(a).

Finding: The Plan did not demonstrate that they ensure beneficiaries receive the beneficiary handbook.

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 is missing the following required element(s):

- California license number and type of license

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, 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 and procedures do not include that re-credentialing occurs every three (3) years.

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 does not require network providers who deliver covered services to sign a written attestation regarding their credentials.

6.0 GRIEVANCE, APPEAL, AND FAIR HEARING

The following deficiencies in grievance, appeal, and fair hearing regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 6.37:

Intergovernmental Agreement Exhibit A, Attachment I, II. E. 7.

7. Grievance and Appeal Systems (42 CFR §438.228).
    i. The Contractor shall have in effect a grievance and appeal system that meets the requirements outlined in Article II.G of this Agreement.
    ii. The Contractor shall be responsible for issuing any Notice of Adverse Benefit Determination under 42 CFR Part 431, subpart E. The Department shall conduct random reviews of the Contractor and its providers and subcontractors to ensure that they are notifying beneficiaries in a timely manner.

MHSUD Information Notice 18-010E

Finding: The Plan's grievance and appeals procedure does not include the following requirement:

- Beneficiary may file a grievance at any time.

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, II, F, 1, v – vi, a – c.

v. Annually, the Contractor shall:
   a. Measure and report to the Department on its performance, using the standard measures required by the Department;
   b. Submit to the Department data, specified by the Department, which enables the Department to calculate Contractor's performance using the standard measures identified by the Department; or
   c. Perform a combination of the activities described above.

vi. Performance improvement projects.
   a. The Contractor shall conduct performance improvement projects, including any performance improvement projects required by CMS that focus on both clinical and nonclinical areas.
   b. Each performance improvement project shall be designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction, and shall include the following elements:
      i. Measurement of performance using required quality indicators.
      ii. Implementation of interventions to achieve improvement in the access to and quality of care.
      iii. Evaluation of the effectiveness of the interventions based on the performance measures.
      iv. Planning and initiation of activities for increasing or sustaining improvement.
   c. The Contractor shall report the status and results of each project conducted to the Department as requested, but not less than once per year.

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 components:

- Access to after-hours care.
- Coordination of physical and mental health services with waiver services at the provider level.

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 Providers Report
- Open Admissions 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, 4, 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, 5, v.

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

Finding: The Plan does not ensure that all DMC Medical Directors are aware of and are meeting their responsibilities. Written roles and responsibilities, and code of conduct required of all program Medical Directors were not found.

CD 8.64:

Intergovernmental Agreement Exhibit A, Attachment I, II, H, 3, I, d.

iii. The Contractor shall submit to the Department the following data:

The annual report of overpayment recoveries as required in 42 CFR §438.608(d)(3).42 CFR §438.608(d).

Treatment of recoveries made by the MCO, PIHP or PAHP of overpayments to providers.

Contracts with a MCO, PIHP, or PAHP must specify:

The retention policies for the treatment of recoveries of all overpayments from the MCO, PIHP, or PAHP to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

ii. The process, timeframes, and documentation required for reporting the recovery of all overpayments.

iii. The process, timeframes, and documentation required for payment of recoveries of overpayments to the State in situations where the MCO, PIHP, or PAHP is not permitted to retain some or all of the recoveries of overpayments.

Finding: The Plan does not have a written procedure for the prompt reporting to DHCS of all overpayments identified or recovered.