Alameda County Behavioral Health Care Services MENTAL HEALTH & SUBSTANCE USE SERVICES	DocuSigned by: By ____ Karyn L. Tribble, PsyD, LCSW, Director BA1070A6C0D444A...
POLICY TITLE **Contract Compliance and Sanctions for ACBH-Contracted Providers**	**Policy No: 1302-1-1** **Date of Original Approval**: 6/15/2018 **Date(s) of Revision(s):** 12/8/2022

PURPOSE

The purpose of this policy is to:

1. Promote operational improvements and quality services;
2. Reduce audit, legal and financial risk for Alameda County Behavioral Health Care Services (ACBH), its Contracted Providers and the network of public-funded behavioral health programs;
3. Clarify the terms and process under which ACBH oversees the implementation of:
   a. Contract Compliance Plans (CCPs) through the Contracts Unit (CU), System of Care (SOC) Operations, and/or other ACBH lead units for a given compliance area;
   b. Quality Improvement Plans (QIP's) and Corrective Action Plans (CAP's) through the ACBH Quality Management (QM) Office; and
   c. Administrative and Financial Sanctions through the CU and other ACBH offices to hold providers accountable for implementing County, State and Federal Requirements;
4. Maximize the effectiveness of publicly-funded behavioral health services to support individuals and families within Alameda County; and
5. Respond to prior Alameda County Audit and Grand Jury Findings around the need to implement standard accountability measures/systems of County-funded programs;

AUTHORITY

- California Code of Regulations (CCR), Title 22 §51341.1
- CCR, Title 9, §§1810.323, 1810.380, 1810.385
- California Department of Health Care Services (DHCS) contract with ACBH
- California DHCS Mental Health Substance Use Disorder (MHSUDS) Information Notice No.18-024
- Code of Federal Regulations (CFR), Title 42 §433.32
- Welfare and Institutions Code §§14124.1, 14712, 14713, 14714, 14707.5

SCOPE

This policy applies to all ACBH-contracted entities who operate programs that provide behavioral health services to consumers.

POLICY

ACBH will hold providers accountable for implementing County, State and Federal requirements. ACBH will communicate expectations, provide training and technical assistance (TA), conduct monitoring, and follow-up with providers on identified regulatory deficiencies. ACBH will oversee formal CCPs, QIPs, CAPs and sanctions with providers if identified deficiencies persist beyond what ACBH determines as a reasonable timeframe for resolution. It is ACBH policy to review existing provider capacity, including any significant deficiencies and/or sanctions, in evaluating the provider's ability to receive new programs and contracts.

Examples of deficiencies that may lead to a CCP, QIP, CAP and/or sanctions include, but are not limited to:

- Lack of qualified staff;
- A client health or safety issue;
- A significant and substantiated client grievance;
- Substantive underperformance on meeting contractual deliverables around quantity/quality of services;
- Lack of fire clearance or other required certification and/or licensure;
- Failure to meet clinical documentation standards for claiming for services provided to beneficiaries;
- Failure to submit required documentation, including contractual documents, invoice documents, programmatic reports, staffing change attestation for Federal and State exclusion list checks, and/or audited financial statements;
- Lack of compliance with other County, State and/or Federal Requirements as specified in a provider contract;
- Repeated and uncorrected findings of non-compliance, and/or
- Lack of achievement in meeting ACBH performance standards including but not limited to, access, and/or quality review requirements.

PROCEDURE

I. Communication and Technical Assistance (TA)

   A. ACBH will communicate and provide TA to providers of existing and emerging regulatory requirements through contractual documents, the ACBH provider website, memos, emails, trainings, meetings, and/or one-on-one TA.

   B. Providers must follow-up with ACBH if they require additional TA or consultation about any of the stated requirements, or any challenges or barriers that they may be facing within their contracted program(s).

II. Monitoring and Informal Resolution Process

   A. ACBH will conduct provider compliance monitoring of County, State and Federal Requirements through review of submitted data, reports, site visits and informal communication with providers about their administrative infrastructure and contracted program(s).

   B. The responsible staff within the responsible ACBH unit, such as the assigned QA Site Certification Lead or Program/Fiscal Contract Manager, will bring identified concerns or deficiencies to the contracted providers in a timely manner, with the goal of quickly addressing these issues through discussion and TA whenever possible.

      1. For contract compliance issues, the goal will be to quickly address the identified issues in an informal and collaborative manner.

         a. Contract compliance issues may be addressed in an informal manner. The responsible staff within ACBH will coordinate with a contact within the provider organization on the steps and timeframe for resolving any concerns or deficiencies, and will follow-up on the provider's progress.

         b. QA compliance issues may be addressed by corrective actions going forward and there may not be the option of pursuing the needed QA corrections in an informal and collaborative manner.

C. If it occurs that a deficiency(ies) will not be addressed in a reasonable timeframe, the responsible staff within ACBH will notify the Provider of the intent of ACBH to initiate a formal process. The responsible staff within ACBH will:
   1. Summarize the identified deficiency(ies) and their work with the provider to date to clarify expectations and resolution addressing the deficiency(ies).
   2. Work with supervisor and/or other relevant ACBH partners to determine next steps to take to address the identified deficiency(ies) and notify the Provider in writing of the timeframes and measures to be taken. Next steps may include, but are not limited to, the following:
      a. Additional communication and TA with the same or different individuals within the provider's organization
      b. Moving to a formal resolution process as described below. In this case, an organization's Executive Director shall be notified.
   3. The responsible staff within ACBH will continue to monitor and communicate with supervisor and/or other relevant ACBH partners until there is documentation that all identified issues have been addressed.

III. Formal Resolution Process

A formal resolution is a resolution that includes the request for any of the following from a ACBH-contracted provider by either ACBH, California DHCS, or any other regulatory body:

- CCPs;
- QIPs; or
- CAPs.

A formal resolution may also include implementation of sanctions.

A. **Requests for CCPs, QIPs, and/or CAPs Initiated by ACBH**
   1. Upon determination that ACBH will be requesting a CCP from a ACBH-contracted provider, the relevant ACBH Director and/or SOC Operational Lead(s) will communicate the concerns related to the CCP verbally and/or in writing to members of the ACBH Executive Team.
      a. For a CCP, it is the responsibility of the ACBH Director, or designee, to ensure that the Alameda County Health Care Service Agency (HCSA) Director and any involved members of the Board of Supervisors are briefed, when applicable, before or directly after the request for CCP is issued.
   2. Requests to ACBH-contracted providers for QICs and CAPs by the Quality Management (QM) Program will be copied to a member of the ACBH Executive Team and/or SOC Operational Lead(s) as well as to ACBH Contract Managers.
   3. ACBH-initiated requests for CCPs, QIPs, and CAPs must include:
      a. A short introduction to provide context;
      b. A description of the identified concerns/deficiency(ies);
      c. Specific requirements of the request, outlining ACBH expectations within a specified timeframe(s). Timeframe(s) for resolution of issue(s) are generally:
         1) Commensurate with the nature of the deficiency(ies) and anticipated time to appropriately resolve for a CCP;

2) Ninety days for a QIP or CAP related to medical chart review; and
3) Thirty days for most other QIPs or CAPs.

d. Timeline and logistics for provider to submit their CCP, QIP, or CAP will generally be thirty days, but longer for a CAP if provider submits an appeal. Exact timeline will be specified in the request to provider.

e. If applicable, the format and frequency of status reports to ACBH regarding progress on the CCP, QIP, or CAP;

f. An overview of potential next steps ACBH will consider if the provider is unable to address the concerns/deficiencies in the allotted timeframe; and

g. Who to contact in ACBH if the provider has additional questions or concerns.

4. The responsible ACBH staff who drafts the request for CCP, QIP, or CAP will:
   a. For CCPs, route the documents to their Director or designee for final review.
   b. For QIPs and CAPs, route to QA Administrator or designee for final review.
5. The request for a CCP will be addressed to the Executive Director or equivalent position within the provider organization. The following staff from ACBH will also be copied as appropriate: Deputy Director, Finance Director, SOC Operational Lead(s), CU Director, CU Assistant Director, CU Fiscal Supervisor, CU Program Contract Manager, CU Fiscal Contract Manager, QA Administrator, QA Lead Staff, and leads from other relevant units. The HCSA Director may also be copied in some instances.
   a. All requests for CCPs will be sent to the provider via email from the CU or other responsible unit.
6. The request for a QIP or CAP will be addressed to the Designated Director/Division Director of the provider organization with the QA lead from the provider organization copied. The following staff from ACBH or their designee will also be copied: Director, Deputy Director, QM Director, QA Administrator, Finance Director, Data Analytics and Cost Reporting Director, BBSU Director, System of Care Director, CU Director, CU Assistant Director, and QA Lead Staff.
7. It is the responsibility of the ACBH CU Director and/or ACBH QM Director or designee to keep the ACBH Executive Team abreast of the provider's progress on meeting the terms of the CCP, QIP, or CAP, next steps, and vetting any sanctions requiring approval from the ACBH Executive Team. For CCPs, it will be the responsibility of the ACBH Director or designee to keep the HCSA Director and relevant members of the Board of Supervisors apprised of the same.

B. **Requests for CAPs Initiated by California DHCS**

1. Upon notification that DHCS has requested a formal CAP for a ACBH-contracted program, for either Post Service Post Payment (PSPP CAP) or a Technical Assistance CAP (TA CAP) for Drug Medi-Cal (DMC) services, the QA Administrator or designee will send a copy of the CAP to relevant ACBH staff including, but not limited to, the following: Director or designee, Deputy Director or designee, System of Care Director, QM Program Director, QA Administrator, Finance Director, Cost Reporting Director, BBSU Director, CU Director, and CU Assistant Director.
2. The ACBH QA staff responsible for monitoring and overseeing the CAP will:

a. Ensure and attest that the CAP submitted to DHCS on behalf of the provider documents planned activities to ensure compliance with all specifications of the requested CAP in accordance with required timeframes;
b. Within four months of the date of DHCS acceptance of the PSPP CAP, conduct a desk and/or onsite review to document implementation of the PSPP CAP and compliance with all required corrections as outlined in the initial DHCS request for the CAP;
c. Liaise with DHCS, key representatives from the provider organization, and any other relevant ACBH parties if there are flags that the provider will be or has been unable to achieve the terms of the CAP within the allotted timeframe;
d. Conduct annual monitoring for implementation and continued compliance with the provisions of the DHCS approved PSPP CAP. Annual PSPP CAP implementation and compliance reviews will continue as scheduled until the next DHCS PSPP utilization review starts a new cycle; and
e. At the end of the PSPP CAP review period, summarize in writing the provider's progress on meeting each of the terms of the CAP and next steps and/or sanctions, if applicable.

3. It will be the responsibility of the ACBH QA Administrator or designee to keep the ACBH Executive Team abreast of the provider's progress on meeting the terms of the CAP, and next steps.

C. **Sanctions and/or Termination**

1. A sanction is an action deemed necessary taken by ACBH to act upon an outstanding deficiency to promptly ensure contract and performance compliance. Sanctions may include, but are not limited to:
   a. 1st level sanctions:
      - Delay payments to provider (i.e., payment hold) until deficiency is addressed;
      - Deny a portion of requested payments for activities not in compliance;
      - Suspend services or new referrals; and/or
      - Reduce funding in next contract.
   b. 2nd level sanctions:
      - Terminate the contracted program or the entire contract;
      - Decline to renew contracted program;
      - Initiate Federal suspension or debarment proceedings; and/or
2. Other legally available actions.
3. ACBH may consider implementing escalating administrative and/or financial sanctions in response to provider non-compliance.
4. If the California DHCS levies any administrative or financial sanctions against ACBH as a result of provider's non-compliance with State or Federal regulations, ACBH may pursue reimbursement of such costs from the provider.
5. In relation to QA audits, ACBH will generally first pursue a QIP or CAP. In relation to other contract compliance issues, ACBH will generally first pursue informal resolution, 1st level sanctions, or a CCP. ACBH will be more likely to consider moving to 2nd level sanctions when it is a prolonged-outstanding issue, or when a

provider is unable to show adequate progress, as defined by ACBH, on meeting the requirements of a CCP, QIP, or CAP.

6. ACBH will pursue 2nd level sanctions when a provider is unable to adequately and timely address noted concerns/deficiencies within a three to nine month period (depending on the nature of the corrections requested). In limited circumstances, ACBH may allow a provider an additional three months to fully address identified concerns/deficiencies if substantive progress or very extenuating circumstances have been noted in the preceding period. The maximum time frame for any identified issue to be resolved is twelve months.
7. ACBH may move immediately or on a shorter timeline to 2nd level sanctions related to an identified deficiency under certain circumstances, which include, but are not limited to:
   a. Urgent client health and safety issues, where ACBH may need to suspend operations until the identified issue is addressed;
   b. Evidence that another funder has terminated their contract with an organization due to gross violations related to client care and/or administrative oversight; and/or
   c. Evidence that a regulatory body has revoked a required certification or licensure due to gross violations related to client care and/or administrative oversight.
8. The ACBH Executive Team must approve any 2nd level sanctions, soliciting input and guidance from relevant ACBH units, County Counsel, Alameda County Risk Management, and the Alameda County HCSA Director on an as needed basis.

IV. Significant deficiencies and/or sanctions may impact ACBH's decision to award a provider new program(s) and/or contract(s).

V. Programs and contracts may be terminated or not renewed by ACBH for reasons unrelated to a CCP, QIP, or CAP, such as reduced availability of funding.

CONTACT

ACBH Office	**Current as of**	**Contact**
Contracts Unit (CCPs)	September 2022	CU: (510) 567-8296
Quality Assurance (QIPs & CAPs)	September 2022	QA Office: qaoffice@acgov.org

DISTRIBUTION

This policy will be distributed to the following:

- ACBH Staff
- ACBH County and Contracted Providers
- Public

ISSUANCE AND REVISION HISTORY

Original Authors: Wendi Vargas, CU Director; Donna Fone, LMFT, LPCC, QA Administrator; and Sharon Loveseth, LAADC, SUD Program Specialist
Original Date of Approval: 6/15/2018 by Carol F. Burton, Interim Behavioral Health Director

Revise Author	Reason for Revise	Date of Approval by (Name)
Torfeh Rejali, LMFT, QA Administrator	Policy revised to align with current ACBH policies and to update outdated language.	12/8/2022 by Karyn L. Tribble, PsyD, LCSW, Behavioral Health Director

DEFINITIONS

Term	Definition
Contract Compliance Plan (CCP)	A CCP is requested from providers and monitored/overseen by the ACBH CU or other responsible unit. A CCP may include any issue related to non-compliance with any local, state or federal requirement as implicitly or explicitly stated in the mental health or substance use disorder contract, and may include deficiencies related to individual programs or to a larger contract. A CCP may include reference to outstanding deficiencies noted in a separate QIP or CAP.
Corrective Action Plan (CAP)	A CAP is requested from providers by the ACBH QA Office or California DHCS including any other regulatory body and monitored/overseen by ACBH QA in relation to deficiencies related to quality assurance requirements. CAPS initiated by DHCS can be related to PSPP, utilization review, and/or TA visits.
Quality Improvement Plan (QIP)	A QIP is requested from providers and monitored/overseen by ACBH QA in relation to deficiencies related to a behavioral health program's implementation of stated QA requirements and the deficiencies have not resulted in any disallowances.
Sanction	A sanction is an action taken by ACBH to act upon an outstanding deficiency.

APPENDICES

NONE