DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF GLENN COUNTY FISCAL YEAR 2024-25

Contract Number: 22-20102

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2023 — June 30, 2024

Dates of Audit: February 4, 2025 — February 14, 2025

Report Issued: June 25, 2025

TABLE OF CONTENTS

I. INTRODUCTION

Glenn County Behavioral Health (Plan) is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of providing mental health services to county residents.

Glenn County is located in the northern part of the California Central Valley. The Plan provides services within the unincorporated county and in the cities of Orland and Willows.

As of March 2025, the Plan had a total of 805 members receiving services and a total of 42 active providers.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2023, through June 30, 2024. The audit was conducted from February 4, 2025, through February 14, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on June 5, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On June 24, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated seven categories of performance: Network Adequacy and Availability of Services, Care Coordination and Continuity of Care, Quality Assurance and Performance Improvement, Access and Information Requirements, Coverage and Authorization of Services, Beneficiary Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2017, through June 30, 2020, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was completely closed at the time of the audit. Therefore, this year's audit included a review of documents to ensure that its implementation and effectiveness of the Plan's corrective actions.

The summary of the findings by category follows:

Category 1 – Network Adequacy and Availability of Services

There were no findings noted for this category during the audit period.

Category 2 – Care Coordination and Continuity of Care

There were no findings noted for this category during the audit period.

Category 3 – Quality Assurance and Performance Improvement

There were no findings noted for this category during the audit period.

Category 4 – Access and Information Requirements

The Plan is required to provide a member who is blind or visually impaired, and other individuals with disabilities, with communication materials in the individual's requested formats, including braille. The Plan did not ensure that alternative communication material in brille was available to its members.

Category 5 – Coverage and Authorization of Services

The Plan shall provide or arrange and pay for medically necessary covered SMHS, including Crisis Residential Treatment Services and Adult Residential Treatment Services. The Plan did not ensure the provision of or the ability to arrange and pay for medically necessary Crisis Residential Treatment Services and Adult Residential Treatment Services.

Category 6 – Beneficiary Rights and Protection

There were no findings noted for this category during the audit period.

Category 7 – Program Integrity

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medically necessary services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Specialty Mental Health Services Contract.

PROCEDURE

DHCS conducted an audit of the Plan from February 4, 2025, through February14, 2025, for the audit period of July 1, 2023, through June 30, 2024. The audit included a review of the Plan's policies for providing services, procedures to implement these policies, and the process to determine whether these policies were effective. Documents were reviewed and interviews were conducted with Plan representatives.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

There were no verification studies conducted for the audit review.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Three member referrals from the Managed Care Plan (MCP) to the Mental Health Plan (MHP) and 13 member referrals from MHP to MCP were reviewed for evidence of referrals, initial assessments, progress notes of treatment planning and follow-up care between the MCP and MHP.

Category 3 – Quality Assurance and Performance Improvement

There were no verification studies conducted for the audit review.

Category 4 – Access and Information Requirements

Telehealth Services: Ten member files were reviewed to confirm compliant member consent for telehealth services.

Category 5 – Coverage and Authorization of Services

Authorizations: 11 member files were reviewed for evidence of appropriate treatment authorization process including the concurrent review authorization process.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: Eight grievances were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for review.

Appeals Procedures: Five appeals were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for review.

Category 7 – Program Integrity

There were no verification studies conducted for the audit review.

COMPLIANCE AUDIT FINDINGS

Category 4 – Access and Information Requirements

4.1 LANGUAGE AND FORMAT REQUIREMENTS

4.1.1 ALTERNATIVE FORMAT REQUIREMENTS

The Plan is required to comply with all state and federal statutes and regulations, the term of this Agreement, BHINs, and any other applicable authorities. *(Contract, Ex. E, Sec. 6(H))*

The Plan is required to provide all written materials for beneficiaries in easily understood language, format, and alternative format that take into consideration the special needs of beneficiaries. *(Contract, Ex. A, Att.11, sec.1(A); 42 CFR. § 438.10(d)(6))*.

The Plan is required to provide a member who is blind or visually impaired, and other individuals with disabilities, with communication materials in the individual's requested formats. The standard alternative formats options are large print, audio CD, data CD, and braille. *(Behavioral Health Information Notice (BHIN) 24-007, Effective Communication, Including Alternative Formats, for Individuals with Disabilities)*

Plan Policy *BH-1023, Alternate Formats: Information for Clients who are Visually and/or Hearing Impaired (revised 03/15/2019),* described the Plan's procedures for providing alternative formats of informing materials to meet the needs of visually impaired and/or hearing-impaired members.

Finding: The Plan did not ensure that alternative communication material in braille was available to its members.

Plan Policy *BH-1023* described the Plan's procedures for providing alternative formats of informing materials to meet the needs of visually impaired and/or hearing-impaired members; however, it did not include braille as an alternative format and a process to provide the braille format to members who requested it.

In an interview and written narrative, the Plan stated it is aware of the requirements of BHIN 24-007 and the need to update policy BH-1023. The Plan stated that braille has never been requested by a member and braille is not available at this time as an alternative format.

When the Plan does not ensure alternative formats are made available to beneficiaries, such as braille, it limits their accessibility preventing them from having adequate knowledge to make informed decisions. This can result in poor mental health outcomes due to missed or delayed access to necessary behavioral health services.

Recommendation: Revise and implement policies and procedures to ensure alternative communication material in braille, are available to beneficiaries upon request.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.1 SERVICE AUTHORIZATION REQUEST

5.1.1 AUTHORIZATION OF CRISIS RESIDENTIAL TREATMENT SERVICES AND ADULT RESIDENTIAL TREATMENT SERVICES

The Plan is required to comply with all state and federal statutes and regulations, the term of the contract, with Behavioral Health Information Notices (BHIN), and any other applicable authorities. *(Contract, Exhibit E, section 6(H))*

The Plan shall provide or arrange and pay for medically necessary covered SHMS to members who meet access criteria for receiving SMHS: Crisis Residential Treatment Services and Adult Residential Treatment Services *(Contract, Ex. A, Att. 2, Sec. 2(A))*.

The Plan is required to establish and implement written policies and procedures to address the authorization of Special Mental Health Services (SMHS) in accordance with BHIN 22-016 *(BHIN 22-016; Authorization of Outpatient Specialty Mental Health Services, (April 2022))*

The Plan may delegate duties and obligations to subcontracting entities if the Plan determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. The Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the Department, notwithstanding any relationship(s) that the Mental Health Plan may have with any subcontractor. *(Contract, Exhibit A, Attachment 1, section 3; 42 CFR section 438.230(b)(1))*

Plan Policy *MH-160, Concurrent Review of Psychiatric Inpatient Hospital, Psychiatric Health Facility, Crisis Residential Treatment, and Adult Residential Treatment Services (effective 05/01/2022)*, stated that the Plan will utilize its Acentra Concurrent Review provider administered by CalMHSA. The policy also stated that the Plan shall utilize referral and/or concurrent review and authorization for all CRTS and ARTS and that all services requiring concurrent review must submit requests using the Atrezzo System, Acentra's portal platform.

Finding: The Plan did not ensure the provision of or the ability to arrange and pay for medically necessary Crisis Residential Treatment Services and Adult Residential Treatment Services.

A review of submitted documents revealed that the Plan does not have a contract with CalMHSA to address and ensure the process of authorization and concurrent review for CRTS and ARTS as stated in Plan Policy MH-160.

The data universe was requested for CRTS/ARTS authorizations. However, the Plan stated that it did not have any member requests for those services during the audit review period.

Concurrent review is required to identify CRTS/ARTS – eligible members based on medical necessity. After identifying CRTS/ARTS - eligible members, authorization of these services follows. Plans may subcontract with organizations who conduct concurrent reviews or conduct the process themselves. In an interview, the Plan stated that, its subcontractor, Acentra, is responsible for conducting concurrent reviews; however, the Plan failed to provide a contract, or other evidence, to validate Acentra had agreed to provide this service. Therefore, without an established subcontractor to conduct concurrent review, the Plan lacks a system to identify and authorize medically necessary CRTS/ARTS. Moreover, without a concurrent review system, the Plan is unable to ensure the provision of or the ability to arrange and pay for medically necessary CRTS/ARTS.

When the Plan does not utilize a referral and/or concurrent review and authorizations for all CRTS/ARTS, the Plan cannot ensure members are receiving medically necessary services.

Recommendation: Implement policies and procedures for services authorization requests and concurrent review processes for CRTS/ARTS.