

DHCS AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SPECIALTY MENTAL HEALTH REVIEW SECTION

**REPORT ON THE SPECIALTY MENTAL HEALTH
SERVICES (SMHS) AUDIT OF ALPINE COUNTY
BEHAVIORAL HEALTH SERVICES
FISCAL YEAR 2025-26**

Contract Number: 22-20093

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2024 — June 30, 2025

Date of Audit: November 5, 2025

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I. INTRODUCTION

Alpine County Behavioral Health Services (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.

Alpine County is located in the eastern part of California within the Sierra Nevada on the state border with Nevada. The Plan provides services within the unincorporated county. All communities in Alpine County are unincorporated.

As of July 9, 2025, the Plan had a total of 22 members receiving services and a total of one active provider.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2024, through June 30, 2025. The audit was conducted on November 5, 2025. The audit consisted of documentation review. The Plan did not provide interviews with the Plan's representatives.

An Exit Conference with the Plan was held on March 27, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On April 20, 2026, 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 five categories of performance: Care Coordination and Continuity of Care, Access and Information Requirements, Coverage and Authorization of Services, Member Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2019, through June 30, 2022, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was completely closed at the time of the audit. Therefore, this audit included a review of documents to determine the implementation and effectiveness of the Plan's corrective actions.

The summary of the findings by category follows:

Category 2 – Care Coordination and Continuity of Care

The Plan is required to implement procedures to coordinate services between settings of care and to utilize the Adult and Youth Screening and Transition of Care Tools.

Finding 2.1.1: The Plan did not demonstrate compliance with the requirement to implement procedures to coordinate services between settings of care and to utilize the Adult and Youth Screening and Transition of Care Tools.

Category 4 – Access and Information Requirements

The Plan is required to provide all written materials for members in alternative formats, such as braille. Finding 4.1.1: The Plan did not ensure alternative formats, including braille, were available to its members.

The Plan is required to ensure all providers explain and document all required elements listed in Behavioral Health Information Notice (BHIN 23-018) when collecting telehealth consents prior to the delivery of telehealth services. Finding 4.4.1: The Plan did not ensure all providers explained and documented all required elements listed in BHIN 23-018 when collecting telehealth consents prior to the delivery of telehealth services.

Category 5 – Coverage and Authorization of Services

The Plan is required to establish and ensure safeguards are in place to suppress confidential information and prevent them from being inappropriately delivered to the minor’s parent or guardian, where involvement of the parent or guardian is determined to be inappropriate, as stated in BHIN 24-046. Finding 5.1.1: The Plan’s policy did not include the updated requirements for minor consent as outlined in BHIN 24-046.

The Plan is required to follow the procedures indicated in BHIN 22-017 in order to conduct concurrent review and authorize administrative days. Finding 5.2.1: The Plan did not demonstrate compliance with the requirements for conducting concurrent reviews for inpatient services and authorizing administrative days as indicated in BHIN 22-017.

The Plan is required to comply with the requirements to utilize referral and/or concurrent review and authorizations for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS) as indicated in BHIN 22-016. Finding 5.2.2: The Plan did not demonstrate compliance with requirements to utilize referral and/or concurrent review and authorizations for all CRTS and ARTS as indicated in BHIN 22-016.

The Plan is required to comply with the requirements for presumptive transfer as indicated in BHIN 24-025. Finding 5.3.1: The Plan did not demonstrate compliance with presumptive transfer requirements as indicated in BHIN 24-025.

Category 6 – Member Rights and Protection

The Plan is required to have written policies and procedures regarding its grievance and appeal system and procedures for filing grievances and appeals available on the Plan’s website. Finding 6.1.1: The Plan did not demonstrate compliance with the requirement to have written policies and procedures regarding its grievance and appeal system and procedures for filing grievances and appeals available on the Plan’s website.

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 on November 5, 2025, for the audit period of July 1, 2024, through June 30, 2025. 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. The Plan did not provide interviews with the Plan's representatives, which made it difficult to determine compliance.

The following verification studies were conducted:

Category 2 – Care Coordination and Continuity of Care

There were no verification studies conducted for the audit review.

Category 4 – Access and Information Requirements

Member Telehealth Consent: Eight telehealth consent samples were reviewed for evidence of documentation of telehealth consent prior to the initial delivery of telehealth services.

Category 5 – Coverage and Authorization of Services

There were no verification studies conducted for the audit review.

Category 6 – Member Rights and Protection

There were no verification studies conducted for the audit review.

Category 7 – Program Integrity

There were no verification studies conducted for the audit review.

COMPLIANCE AUDIT FINDINGS

Category 2 – Care Coordination and Continuity of Care

2.1 Coordination of Care Requirements

2.1.1 Care Coordination Services

The Plan is required to comply with all state and federal statutes and regulations, the terms of the Contract, with BHINs, and any other applicable authorities. (*Contract, Exhibit E, section (6)(H)*)

The Plan must implement procedures to deliver care to and coordinate services for all of its members, including the services the Plan furnishes to the member between settings of care, with appropriate discharge planning for short-term and long-term hospitals and institutional stays, and the services the Plan furnishes to the member with the services the member receives from any other managed care organizations, in Fee-For-Service (FFS) Medi-Cal, from community and social support providers, and other human services agencies used by its members. (*Contract, Exhibit A, Attachment 10, section 1(A)(2)*)

The Plan must develop and implement written policies and procedures to ensure that members meeting criteria for Non-Specialty Mental Health Services (NSMHS), as indicated by a DHCS-approved standardized transition tool, are referred to the Managed Care Plan (MCP) or an FFS provider offering NSMHS. Likewise, the Plan must develop and implement written policies and procedures to ensure that members meeting criteria for SMHS, as indicated by a DHCS-approved standardized transition tool, are referred by the MCP to the Plan. (*Contract, Exhibit A, Attachment 10, section 1(D)(3)*)

The Adult and Youth Screening Tools for Medi-Cal Mental Health Services shall be used by Mental Health Plans (MHPs) when a member, or a person on behalf of a member under age 21, who is not currently receiving mental health services, contacts the MHP seeking mental health services. The tools are to be used to guide a referral by the MHP to the appropriate Medi-Cal mental health delivery system (i.e., MCP or MHP). The Adult Screening Tool shall be used for members aged 21 and older. The Youth Screening Tool shall be used for members under age 21. The Adult and Youth Screening Tools identify initial indicators of member needs in order to make a determination for referral to either the member's MCP for a clinical assessment and medically necessary NSMHS or to the member's MHP for a clinical assessment and medically necessary SMHS. (*BHIN 22-065,*

Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services, (December 2022), p.4)

The Transition of Care Tool is designed to leverage existing clinical information to document a member's mental health needs and facilitate a referral for a transition of care to, or addition of services from the member's MCP or MHP, as needed. *(BHIN 22-065, Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services, (December 2022), p.10)*

Finding: The Plan did not demonstrate compliance with the requirement to implement procedures to coordinate services between settings of care and to utilize the Adult and Youth Screening and Transition of Care Tools.

In an email dated November 5, 2025, the Plan stated that it would not provide interviews or additional documentation to verify compliance.

The Plan did not provide the requested policies and procedures for coordinating services between settings of care as well as utilizing DHCS-approved standardized transition tools, including Adults and Youth Screening Tools and Transition of Care Tools.

In a narrative dated July 30, 2025, the Plan also confirmed that it did not have staff training or records to prove that care coordination services were discussed during the audit period.

When the Plan does not provide documentation demonstrating compliance with contract requirements, it cannot ensure the coordination of services. This can lead to fragmented care, negatively impacting the health outcomes of members.

Recommendation: Develop and implement policies and procedures for coordinating services between settings of care and utilizing the Adult and Youth Screening and Transition of Care Tools.

COMPLIANCE AUDIT FINDINGS

Category 4 – Access and Information Requirements

4.1 Language and Format Requirements

4.1.1 Alternative Formats

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

The Plan is required to provide all written materials for members in easily understood language, format, and alternative formats that take into consideration the special needs of members. *(Contract, Exhibit A, Attachment 11 (1)(A))*

Medi-Cal Behavioral Health delivery systems (MHPs, Drug Medi-Cal-Organized Delivery System counties, and Drug Medi-Cal counties), and their subcontractors must provide a member who is blind or visually impaired, and other individuals with disabilities, with communication materials in the individuals' requested standard and non-standard alternative format(s).

The standard alternative formats options are: Large print, audio CD, data CD, and braille.

- Large print: At least 20pt font or larger
- Audio CD: Provides the ability to hear notices and information. Files in the CD are not encrypted.
- Data CD: This allows for the use of computer software to read notices and other written information. Files in the CD are not encrypted.
- Braille: Uses raised dots that can be read with fingers.

(BHIN 24-007, Effective Communication, Including Alternative Formats, for Individuals with Disabilities)

Plan policy AC-164, *Information Requirements – Alternative Language Formats* (effective June 12, 2025) stated that the Plan will obtain written materials from a DHCS-approved vendor in braille and other language formats for individuals who request materials in braille or digitally.

Finding: The Plan did not ensure alternative formats, including braille, were available to its members.

In an email dated November 5, 2025, the Plan stated that it would not provide interviews or additional documentation to verify compliance.

When the Plan does not provide documentation demonstrating compliance with contract requirements, it cannot ensure the provision of alternative formats, including braille, to members. This limits members' access and prevents 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 formats, including braille, are available to members upon request.

4.4 Specialty Mental Health Services Via Telehealth

4.4.1 Member Consent for Telehealth

The Plan is required to comply with all state and federal statutes and regulations, the terms of the Contract, with BHINs, and any other applicable authorities. (*Contract, Exhibit E, section (6)(H)*)

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 DHCS, notwithstanding any relationship(s) that the Plan may have with any subcontractor. (*Contract, Exhibit A, Attachment 1, section 3; Code of Federal Regulations (CFR), Title 42, section 438.230(b)(1)*)

The Plan has an affirmative responsibility to obtain member consent prior to initial delivery of covered services via telehealth. Providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services, and must explain the following to members: the member has a right to access covered services in person; use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the member's ability to access Medi-Cal covered services in the future; non-medical transportation benefits are available for in-person visits; and any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable. (*BHIN 23-018*,

Updated Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal)

Plan's policy AC-820, *Telehealth Services (effective March 25, 2025)* stated that prior to initial delivery of SMHS services via telehealth, the Plan and its contract providers are required to document oral or written consent for the use of telehealth as an acceptable mode of delivering services. The consent must include the following: (1) The member has a right to access covered services in person; (2) Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the member's ability to access Medi-Cal covered services in the future; (3) Non-medical transportation benefits are available for in-person visits; (4) Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable. The Plan obtains written or oral consent from the member and documents the consent in the member's electronic health record.

Finding: The Plan did not ensure all providers explained and documented all required elements listed in BHIN 23-018 when collecting telehealth consents prior to the delivery of telehealth services.

In a verification study, all eight member records reviewed revealed that the subcontractor's consent form was used and was obtained prior to the delivery of SMHS. However, all eight consent forms were missing the following two required elements: (1) The member has a right to access covered services in person and (2) Non-medical transportation benefits are available for in-person visits.

The Plan submitted two blank telehealth consent forms: one from the Plan and another from its subcontractor. Both telehealth consent forms were missing the following two required elements: (1) The member has a right to access covered services in person and (2) Non-medical transportation benefits are available for in-person visits.

In an email dated November 5, 2025, the Plan stated that it would not provide interviews or additional documentation to verify compliance.

When the Plan does not ensure telehealth consent included all required elements before rendering telehealth services to members, it can result in members not having adequate knowledge about treatment options.

Recommendation: Implement policies and procedures to ensure all-providers explain and document all required elements listed in BHIN 23-018 when collecting telehealth consents prior to the delivery of telehealth services.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.1 Service Authorization – Concurrent Review and Prior Authorization Requirements

5.1.1 Minor Consent to Outpatient Mental Health Treatment or Counseling

The Plan is required to comply with all state and federal statutes and regulations, the terms of the Contract, with BHINs, and any other applicable authorities. (*Contract, Exhibit E, section (6)(H)*)

- A. A minor who is 12 years of age or older can consent to outpatient mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently.
- B. Where involvement of the parent or guardian is determined to be inappropriate, MHPs and providers shall establish and ensure safeguards are in place to suppress confidential information and prevent appointment notifications, Notice of Adverse Benefit Determination documents, and any other communications that would violate the minor's confidentiality from being inappropriately delivered to the minor's parent or guardian.

Following consultation with the minor, the professional person must note their determination regarding the appropriateness of involvement of the parent or guardian in the member record, stating either:

- 1. Whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful.
- 2. The reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

(BHIN 24-046, Minor Consent to Outpatient Mental Health Treatment or Counseling)

Plan policy AC-112, *Consent for Treatment of Minors – Mental Health Services (revised December 2, 2019)* stated a minor may consent to their treatment if they meet the following requirements: (1) the minor is age 12 or older; AND (2) The minor is mature enough to participate intelligently in the treatment. This is consistent with requirement A above.

Finding: The Plan’s policy did not include the updated requirements for minor consent as outlined in BHIN 24-046.

Plan policy AC-112 does not fully address the updated requirements for minor consent as outlined in BHIN 24-046. It did not have the procedures that the Plan has to perform in situations where involvement of the parent or guardian is determined to be inappropriate (Requirement B above).

In an email dated November 5, 2025, the Plan stated that it would not provide interviews or additional documentation to verify compliance.

When the Plan's policy does not include all the documentation requirements specified in BHIN 24-046, this can compromise the continuity and quality of care for minor members receiving mental health treatment or counseling services.

Recommendation: Revise and implement policy and procedures to reflect the updated requirements for minor consent as outlined in BHIN 24-046.

5.2 Treatment Authorization – Concurrent Review

5.2.1 Concurrent Review for Inpatient Services and Authorizing Administrative Days

The Plan is required to comply with all state and federal statutes and regulations, the terms of the Contract, with BHINs, and any other applicable authorities. (*Contract, Exhibit E, section (6)(H)*)

MHPs are required to operate a utilization management (UM) program that ensures members have appropriate access to SMHS. The UM program must evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal members prospectively, such as through prior or concurrent authorization review procedures. (*BHIN 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services; California Code of Regulation (CCR), Title 9, section 1810.440(b); CFR, Title 42, section 438.210 (a)(4), (b)(1),(2).*)

In order to conduct concurrent review and authorization for administrative day service claims, the Plan shall review that the hospital has completed and documented, up to five contacts within the seven-consecutive-day period, to a non-acute residential treatment facility per day, starting with the day the member is placed on administrative day status. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented. The

Plan may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the member. (BHIN 22-017, *Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services*; CCR, Title 9, section 1820.230; *Welfare and Institutions Code sections 14184.402, 14184.102 and 14184.400.*)

Plan policy AC-172, *Inpatient Treatment Authorization Requests (TARs)* (revised August 28, 2024) stated the Plan begins daily concurrent review as soon as a member's admission is known. The Plan tracks inpatient admissions, concurrent reviews, and TAR processing via a Concurrent Review Log and TAR Checklist, which include at least the following: member identifying information; inpatient admit and discharge dates; total days of hospitalization (length of stay); date that TAR was received; concurrent review dates and disposition; number of days approved by the Plan; date that TAR was approved and sent to the California Medicaid Management Information System Fiscal Intermediary; funding source; and any provider appeals of denials or modifications.

Finding: The Plan did not demonstrate compliance with the requirements for conducting concurrent reviews for inpatient services and authorizing administrative days as indicated in BHIN 22-017.

The Plan did not provide medical records for the four members that had received inpatient services during the audit period. As a result, DHCS was unable to conduct a verification study to assess the Plan's level of compliance in providing referral-based authorizations for conducting concurrent reviews for inpatient services and authorizing administrative days.

In an email dated November 5, 2025, the Plan stated that it would not provide interviews or additional documentation to verify compliance.

When the Plan does not ensure the concurrent review procedures for the authorization of psychiatric inpatient hospital services and authorizing administrative days, it can negatively impact the Plan's ability to ensure members are receiving services and result in poor health outcomes.

Recommendation: Implement policy and procedures to ensure the Plan conducts concurrent reviews for inpatient services and authorize administrative days as indicated in BHIN 22-017.

5.2 Treatment Authorization – Concurrent Review

5.2.2 Concurrent Review and Prior Authorization Requirements

The Plan is required to comply with all state and federal statutes and regulations, the terms of the Contract, with BHINs, and any other applicable authorities. (*Contract, Exhibit E, section (6)(H)*)

MHPs must utilize referral and/or concurrent review and authorization for all CRTS and ARTS. MHPs may not require prior authorization.

1. If the MHP refers a member to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the MHP specifies the parameters (e.g., number of days authorized) of the authorization.
2. The MHP must then re-authorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the member's stay and based on member's continued need for services.

(BHIN 22-016, Authorization of Outpatient SMHS)

Finding: The Plan did not demonstrate compliance with requirements to utilize referral and/or concurrent review and authorizations for all CRTS and ARTS as indicated in BHIN 22-016.

The Plan did not provide requested policies and procedures, or utilization reports to demonstrate the provision of CRTS and ARTS. As a result, DHCS could not evaluate if the Plan was in compliance with referral and/or concurrent review and authorization for all CRTS and ARTS as indicated in BHIN 22-016.

In an email dated November 5, 2025, the Plan stated that it would not provide interviews or additional documentation to verify compliance.

When the Plan does not have policies and procedures for referral, concurrent review, and authorization processes for CRTS and ARTS, it can negatively impact the Plan's ability to ensure members are receiving services and result in poor health outcomes.

Recommendation: Develop and implement policies and procedures to ensure concurrent review for authorizations of CRTS and ARTS as indicated in BHIN 22-016.

5.3 Presumptive Transfer

5.3.1 Presumptive Transfer

The MHP in the county of original jurisdiction of a child or youth in foster care shall retain responsibility to provide or arrange, and pay for, SMHS if the child or youth in foster care is placed out of the county of original jurisdiction in a Child and Family Team (CFT), Group Home, or Short-Term Residential Therapeutic Program, or is admitted to a Children’s Crisis Residential Program, unless either of the following circumstances exist:

1. The child or youth’s case plan specifies that the child or youth will transition to a less restrictive placement in the same county as the facility in which the child has been placed or admitted; or
2. The placing agency determines, as informed by the CFT, that the child or youth will be negatively impacted if responsibility for providing or arranging for SMHS is not transferred to the same county as the facility in which the child has been placed or admitted. The placing agency shall document the basis for making this determination in the case record.

(BHIN 24-025, Presumptive Transfer Related to Children and Youth in Foster Care Placed in Out-of-County Short-Term Facilities)

Finding: The Plan did not demonstrate compliance with presumptive transfer requirements as indicated in BHIN-24-025.

The Plan did not submit any requested policies and procedures regarding the presumptive transfer requirements.

In an email dated November 5, 2025, the Plan stated that it would not provide interviews or additional documentation to verify compliance.

When the Plan does not have a policy or procedure for presumptive transfer it may lead to poor communication between counties, providers, and caregivers, resulting in delays in care coordination and effective service delivery.

Recommendation: Develop and implement policies and procedures to ensure the Plan is compliance with presumptive transfer requirements as indicated in BHIN 24-025.

COMPLIANCE AUDIT FINDINGS

Category 6 – Member Rights and Protection

6.1 Grievance and Appeal System Requirements

6.1.1 Member Problem Resolution System

The Plan must have a grievance and appeal system in place for members to handle appeals of adverse benefit determinations and grievances and shall include processes to collect and track information about them. The Plan's member problem resolution processes must include a grievance process; an appeal process; and an expedited appeal process. (*Contract, Exhibit A, Attachment 12, section 1(A)*)

The Plan shall establish, implement, and maintain a grievance and appeal system to ensure the receipt, review, and resolution of grievances and appeals. The grievance and appeal system shall operate in accordance with all applicable federal regulations and Plan contract requirements, as follows:

- A. The Plan shall have, and operate in accordance with, written policies and procedures regarding its grievance and appeal system.
- B. The Plan shall ensure that a description of the procedure for filing grievances and appeals is readily available on the Plan's website.

(*Mental Health Substance Use Disorder Services Information Notice No. 18-010E, March 27, 2018*).

Finding: The Plan did not demonstrate compliance with the requirement to have written policies and procedures regarding its grievance and appeal system and procedures for filing grievances and appeals available on the Plan's website.

The Plan did not provide the requested policies and procedures, nor desktop procedures, or workflows depicting procedures, responsibilities, or timelines.

A description of the procedure for filing grievances and appeals is not available on the Plan's website. The Plan's Guide to County Mental Health Services encourages members to discuss issues directly with their provider, their therapist, the Behavioral Health

Director, or the Privacy/Compliance Officer rather than encouraging members to exercise their right to file a grievance in case of dissatisfaction with a service.

In an email dated November 5, 2025, the Plan stated that it would not provide interviews or additional documentation to verify compliance.

Without a system to inform members how to file grievances and appeals, members may be unaware of their rights or unable to exercise them, resulting in possible delays in accessing the services needed.

Recommendation: Develop and implement policies and procedures for handling grievances and appeals.