DHCS REPORT ON THE SUSTANCE USE DISORDER (SUD) AUDIT OF: TRINITY

2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
BEHAVIORAL HEALTH REVIEW BRANCH

REPORT ON THE SUBSTANCE USE DISORDER (SUD) AUDIT OF

Trinity County Behavioral Health Services
Drug Medi-Cal

2023

Contract Number:	20-10205
Audit Period:	July 1, 2022 Through June 30, 2023
Dates of Audit:	July 25, 2023 Through August 4, 2023
Report Issued:	January 23, 2024

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I. INTRODUCTION

Trinity County Behavioral Health Services (Plan) provides a variety of Drug Medi-Cal (DMC) services for county citizens. The Plan is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of providing DMC services for substance use treatment.

Trinity County is extremely rural and is the fourth smallest county in the State of California. The County has a population total of approximately 16,112 with 5,233 individuals eligible to receive Medi-Cal services. In the 2021 calendar year, the Plan serviced 329 beneficiaries and had a total of nine active providers, two of which were county owned and operated and seven contracted.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS audit of the Plan's DMC programs for the period of July 1, 2022 through June 30, 2023. The audit was conducted from July 25, 2023 through August 4, 2023. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on December 15 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. On January 18, 2024, the Plan submitted a response to address the audit findings. The results of the DHCS evaluation of the Plan's response are reflected in this report.

The audit evaluated three categories of performance: Availability of DMC Services, Quality Assurance and Performance Improvement, and Program Integrity.

The prior DHCS compliance report issued on February 23, 2023, (review period July 1, 2021 through June 30, 2022) identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was not completely closed at the time of the audit; However, this year's audit included review of documents to determine implementation and effectiveness of the Plan's corrective actions.

The summary of the findings by category follows:

Category 1 – Availability of DMC Services

The Plan is required to establish procedures or subcontract for covered Naltrexone Treatment and Perinatal Residential Substance Abuse Services within the service area. The Plan did not ensure to subcontract for covered services in the provision of Naltrexone Treatment and Perinatal Residential Substance Abuse Services.

The Plan is required to follow the Adolescent SUD Best Practices Guide, that superseded the Youth Treatment Guidelines, in developing and implementing youth treatment programs. The Plan did not follow the required guidelines in developing and implementing adolescent treatment programs.

The Plan is required to comply with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate which entitles beneficiaries under the age of 21 to all appropriate and medically necessary services. The Plan did not ensure the provision of EPSDT services for beneficiaries under the age of 21.

Category 3 – Quality Assurance and Performance Improvement

The Plan is required to on a monthly basis, monitor the status of all subcontractors to ensure they maintain active enrollment in the DMC program. The Plan did not ensure to implement all monthly monitoring requirements that include provider enrollment status and timely DHCS notification of reportable events.

The Plan requires subcontractors to have written roles and responsibilities and a code of conduct for the Medical Director that is clearly documented, signed, and dated by a program representative and physician. The Plan did not ensure subcontractors complied with requirements for the existence of the Medical Director's signed written roles and responsibilities.

The Plan is required to regularly assess the substance use service needs of the American Indian/Alaskan Native (AI/AN) population within its geographic area. The Plan did not maintain regular engagements with the Tribal Organization to identify issues and barriers to service delivery, quality improvements, and service accessibility.

The Plan is required to implement and maintain the California Outcomes Measurement System (CalOMS-Tx) Business Rules and Requirements. The Plan did not ensure timely submission of beneficiary annual updates to the CalOMS Tx System.

Category 7 – Program Integrity

Audit of category seven yielded no findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted this audit of the Plan to ascertain that SUD services provided to Plan beneficiaries comply with federal and state laws, Medi-Cal regulations and guidelines, and the state's DMC Contract.

PROCEDURE

The audit was conducted from July 25, 2023 through August 4, 2023, for the audit period of July 1, 2022 through June 30, 2023. The audit included a review of the Plan's policies for providing services and evidence of procedures used to implement the policies. Documents were reviewed and interviews were conducted with Plan representatives.

There were no verification studies conducted for this audit.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: TRINITY COUNTY – DRUG MEDI-CAL SERVICES

AUDIT PERIOD: July 1, 2022 through June 30, 2023
DATES OF AUDIT: July 25, 2023 through August 4, 2023

CATEGORY 1 -- AVAILABILITY OF DRUG MEDI-CAL SERVICES

1.1	Availability of DMC Services

1.1.1 Subcontracts for Covered Services

The Plan is required to establish assessment and referral procedures and arrange, provide, or subcontract for covered services in the Plan's service area. Covered services shall include Naltrexone Treatment and Perinatal Residential Substance Abuse Services. *(DMC Contract, Exhibit A, Attachment I, Part I, Section 2)*

Referrals to a non-contracting provider or to another county without an appropriate funding agreement does not fulfill a county's contractual obligation to arrange, provide or subcontract for DMC services. *(Mental Health and Substance Use Disorders Information Notice 18-009)*

Plan policy *5015, Referral Arrangement (revised July 12, 2021)* describes the Plan's policy to make referrals for necessary and appropriate care for covered services such as Naltrexone treatments. To further assist clients in seeking, the Plan will maintain and make available a current list of resources within the community that offer services not provided within the program such as Naltrexone treatment. In the case of a Naltrexone referral, the Plan's SUD program will ensure through the client's chart a confirmed documented history of opiate use disorder, that the client is at least 18 years or older, is opiate free, and is not pregnant.

Finding: The Plan did not subcontract for covered services in the provision of Naltrexone Treatment and Perinatal Residential Substance Abuse Services.

The Plan's Resource Directory did not list network providers rendering Naltrexone treatments. The Plan did not execute subcontractor agreements with appropriate funding arrangements to ensure the provision of Naltrexone treatment in the Plan's service area. Instead, the Plan referred beneficiaries to local clinics for the provision of Naltrexone treatment since these clinics were more accessible to the population served. The Plan and local clinics had no funding agreement for the provision of Naltrexone treatments.

In addition, the Plan did not subcontract with providers of Perinatal Residential Substance Abuse Services. Beneficiaries in need of these services were referred to, and received these services from, an out-of-county residential provider.

In an interview, the Plan stated it was not aware of the requirement to establish subcontracts with providers for covered services for Naltrexone Treatments and Perinatal Residential Substance Abuse Services.

When the Plan does not comply with requirements to subcontract with providers of covered services, the Plan cannot ensure beneficiary access to medically necessary Naltrexone Treatment and Perinatal Residential Substance Abuse Services.

Recommendation: Develop and Implement policies and procedures to subcontract for covered services in the provision of Naltrexone Treatment and Perinatal Residential Substance Abuse Services.

1.2	Adolescent (Youth) Services

1.2.1 Adolescent SUD Guide

The Plan is required to follow the guidelines in Document IV, Youth Treatment Guidelines in developing and implementing youth treatment programs funded under this Exhibit, until new Youth Treatment Guidelines are established and adopted. No formal amendment of this Contract is required for new guidelines to be incorporated into this Contract. *(DMC Contract, Exhibit A, Attachment I)*

The Adolescent SUD Best Practices Guide replaces the previously published *Youth Treatment Guidelines (revised August 2002)*. The guide is developed and intended to be used in place of and, not to conflict with or duplicate, other applicable laws, regulations or standards that govern programs serving adolescents. *(Adolescent Best Practices Guidelines, implemented October 2020)*

Finding: The Plan did not follow and implement the *Adolescent SUD Best Practices Guide (implemented October 2020)* in developing and implementing adolescent treatment programs.

Plan policy *5048 Adolescent Youth Treatment (approved March 1, 2016)* described the *Youth Treatment Guidelines (revised August 2002)*. This policy was not updated to include the requirement to follow the *Adolescent SUD Best Practices Guide (implemented October 2020).*

The Plan's agreement with subcontractor(s) did not list youth services and service compensation rates in accordance with *Adolescent SUD Best Practices Guide (implemented October 2020).*

In an interview, the Plan stated the County had not implemented the *Adolescent SUD Best Practices Guide (implemented October 2020).* The Plan's Mental Health department is responsible in developing and implementing adolescent guidelines; however, the Plan expressed that shortage in staff affected the Plan's ability to comply with implementing the updated adolescent guidelines.

When updated adolescent treatment guidelines are not implemented by the Plan, eligible adolescent beneficiaries may not receive SUD services that meet best practice standards to improve health outcomes and the overall quality of behavioral health care.

Recommendation: Revise and implement policies and procedures to include the *Adolescent SUD Best Practices Guide (implemented October 2020)* in developing and implementing adolescent treatment programs.

1.2.2 EPSDT Services

The Plan is required to comply with the EPSDT mandate which entitles beneficiaries under the age of 21 to all appropriate and medically necessary services coverable under a Medicaid State Plan (as described in the United State Code, Title 42, section 1396d (a)) that are needed to correct or ameliorate discovered health conditions, regardless of whether those services are covered in the state's Medicaid State Plan. *(Behavioral Health Information Notice (BHIN) 22-003)*

Finding: The Plan did not ensure the provision of EPSDT services for beneficiaries under the age of 21.

The Plan lacks policies and procedures describing how the Plan ensures the provision of EPSDT services for eligible beneficiaries.

Plan agreements with subcontractor(s) did not detail how EPSDT services will be provided to eligible beneficiaries.

In an interview, the Plan stated that the Mental Health department is responsible for identifying and coordinating the provision of EPSDT services. However, there was no evidence that this department had a process to identify eligible beneficiaries in need of EPSDT services.

When the Plan does not have a system to identify and coordinate the provision of EPSDT services, eligible beneficiaries under age 21 who may be at risk of a SUD will not be assessed, screened, and provided early intervention services.

Recommendation: Develop and implement policies and procedures to identify and provide EPSDT services to eligible beneficiaries under the age of 21 ensuring compliance with the EPSDT mandate.

❖ COMPLIANCE AUDIT FINDINGS ❖
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CATEGORY 3 -- QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

3.1	Monitoring

3.1.1 Monthly Subcontractor Monitoring

The Plan is required to on a monthly basis, monitor the status of all subcontractors to ensure they maintain active enrollment in the DMC program. The Plan must report the following to the DHCS' Provider Enrollment Division at DHCSDMCRECERT@dhcs.ca.gov within five business days of notification or discovery:

- Any subcontractor that surrenders its certification or closes its facility.
- During the monthly status check, the Plan shall monitor for and report a triggering recertification event including but not limited to change in ownership, change in scope of services, remodeling of facility, or change in location. *(DMC Contract, Exhibit A, Attachment I, Part I, Section 4)*

Plan policy *5003, Program Monitoring (revised November 17, 2022),* describes the Plan's policy to conduct monthly status checks. The policy describes how the Plan conducts monthly status checks of subcontractor(s) for enrollment status, subcontractor's surrender of certification, facility closure, and triggering recertification events.

Finding: The Plan did not ensure to implement all monthly monitoring requirements that include provider enrollment status and timely DHCS notification of reportable events.

The Plan did not consistently monitor the status of subcontractors to ensure they maintained active enrollment in the DMC program. Additionally, the Plan explained the Out of County Referral Log and Master Provider File reports were utilized to review facility certifications on an annual basis.

In the interview, the Plan stated it was not aware of the requirement to notify Provider Enrollment Division when a facility surrenders its DMC certification or closes the facility within five business days of notification or discovery.

When the Plan does not conduct monthly monitoring, quality of care may be impacted when services are rendered by providers who do not meet Medi-Cal Program enrollment standards.

Recommendation: Implement policies and procedures for monthly monitoring to ensure subcontractors maintain active certification in the DMC program.

3.2	Minimum Quality Drug Treatment Standards

3.2.1 Medical Director Roles and Responsibilities

The Plan shall require all the subcontracted providers of covered services to be licensed, registered, DMC enrolled, and/or approved in accordance with applicable laws and regulations. The Plan's subcontracts shall require that providers comply with the following regulations and guidelines, including, but not limited to, Minimum Quality Drug Treatment Standards (MQDTS). *(Contract, Exhibit 1, Attachment I, Part 1, Section 3)*

Compliance with the following MQDTS requires subcontractors to have written roles and responsibilities and a code of conduct for the Medical Director that is clearly documented, signed, and dated by a program representative and physician. *(Minimum Quality Drug Treatment Standards Document 2F(a), A, 5)*

Plan policy *5057 Medical Director Roles and Responsibilities (revised October 24, 2022)* states that subcontractors are required to have written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed, and dated by a program representative and physician.

Finding: The Plan did not ensure subcontractors complied with requirements for the existence of the Medical Director's signed written roles and responsibilities.

To verify compliance with MQDTS standards, four subcontractors were reviewed to verify if they met requirements for the existence of the Medical Director's signed written roles and responsibilities. The Medical Director forms submitted for audit review did not include all required MQDTS elements for Medical Director documents.

Although the Plan had policies and procedures to ensure that Medical Director document requirements were met, the Plan only evaluated one provider for compliance. For this one provider, the Plan noted that the written roles and responsibilities and a code of conduct for the Medical Director was clearly documented, signed, and dated by a program representative and physician. For three providers, the Plan presented the monitoring tools utilized for their subcontractor to demonstrate compliance with annual review requirements. One of the three providers was missing four of the six required Medical Director documents.

In an interview, the Plan explained that subcontractor onsite reviews were conducted annually and that these reviews included the evaluation of required Medical Director documents. However, the Plan did not ensure the subcontractor monitoring tools included all relevant MQDTS elements.

The lack of oversight regarding minimum standards for the subcontractors' Medical Directors may result in beneficiaries not receiving appropriately provisioned services.

Recommendation: Revise and implement policies and procedures to ensure subcontractors meet all requirements for the existence of signed written roles and responsibilities for the Medical Director.

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3.3	Required Subcontractor Provisions

3.3.1 Tribal Community Service Needs Assessment

The Plan shall regularly assess the substance use service needs of the AI/AN population within its geographic area and shall engage in regular and meaningful consultation and collaboration with elected officials of the tribe, Rancheria, or their designee for the purpose of identifying issues/barriers to service delivery and improvement of the quality, effectiveness, and accessibility of services available to AI/AN communities within the County. *(DMC Contract, Exhibit A, Attachment I, Part II, General, H)*

Finding: The Plan did not maintain regular engagements with the Tribal Organization to identify issues and barriers to service delivery, quality improvements, and service accessibility.

The Plan lacked policies and procedures to engage with the Tribal Organization for regularly assessing substance use service needs, determine whether the population was being reached, and survey Tribal Organizations for insight regarding potential barriers.

Although the Plan's agreement with subcontractor(s) regarding Tribal Communities includes the requirement to regularly assess substance use service needs, there is no documented evidence submitted by the Plan showing the implementation of this agreement. In addition, the Plan did not submit evidence of communication or surveys conducted as required for Tribal Communities.

The Plan confirmed in an interview that there are Tribal clinics that provide Mental Health services; however, there was no documentation of communication between the Plan and these Tribal clinics during the audit period.

Without regular engagement and collaboration to identify issues and potential barriers with Tribal Organizations, quality of care may be negatively impacted due to potential lack of access to substance use services.

Recommendation: Develop policies and procedures to maintain regular engagements with the Tribal Organization to identify issues and barriers to service delivery, quality improvements, and service accessibility.

3.4	California Outcomes Management System (CalOMS)

3.4.1 CalOMS Data Collection

The Plan is required to implement and maintain CalOMS-Tx Business Rules and Requirements, such as electronic submission of data within 45 days from the end of the last day of the report month. The Plan (Plan) 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. *(DMC Contract, Exhibit A, Attachment I, Part III, C, (5))*

Plan policy *5042, CalOMS Treatment Data Collection & Reporting (revised November 2022)*, describes CalOMS-Tx Data Compliance Standards established by DHCS for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, annual updates, resubmission of records containing errors or in need of correction, and reporting method. The policy stated that electronic submission of CalOMS-Tx data is required to be submitted by its subcontractors within 45 days from the end of the last day of the report month.

Finding: The Plan did not ensure timely submission of beneficiary annual updates to the CalOMS Tx System.

The Plan's agreement with subcontractor(s) requires the subcontractor to submit CalOMS and Drug and Alcohol Treatment Access Reports to DHCS in a timely manner. However, during the audit the Plan provided a CalOMS Open Admission Report with a zero-month filter which included data for three beneficiaries without timely annual updates.

In an interview, the Plan stated that it lacks a monitoring system to ensure timely submission of CalOMS-Tx data, such as annual updates and that this is an area that needs to be improved.

When the Plan does not monitor and ensure the timely submission of annual updates to the CalOMS Tx system, the beneficiary's treatment plan may lack necessary clinical information, and this can negatively impact care provision and client progress.

Recommendation: Implement policies and procedures to ensure timely submission of beneficiary annual updates to the CalOMS Tx system.