DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

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

Contract Number: 22-20145

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2024 — December 31, 2024

Dates of Audit: February 3, 2026 — February 13, 2026

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I. INTRODUCTION

Tuolumne County Behavioral Health Plan (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.

Tuolumne County is located in the Sierra Nevada region. The Plan provides services within the unincorporated county, Census-designated places, and in the City of Sonora.

As of December 31, 2024, the Plan had a total of 660 members receiving services.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2024, through December 31, 2024. The audit was conducted from February 3, 2026, through February 13, 2026. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on May 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 June 10, 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 six categories of performance: Network Adequacy and Availability of Services, 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 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 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

The Plan is required to coordinate member care services with Managed Care Plans (MCPs) and ensure medically necessary services were made available to members. Finding 2.1.1: The Plan did not coordinate member care services with MCPs to ensure medically necessary services were made available to members.

Category 4 – Access and Information Requirements

The Plan is required to provide all written materials for members in alternative formats, including braille. Finding 4.1.1: The Plan did not ensure that alternative format, braille, was 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

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

Category 6 – Member 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 3, 2026, through February 13, 2026, for the audit period of July 1, 2024, through December 31, 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 the Plan's representatives.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

Mobile Crisis Services: Ten member files were reviewed for evidence of response and follow-up, assessment, documentation, and provision of services in appropriate settings.

Category 2 – Care Coordination and Continuity of Care

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

Category 4 – Access and Information Requirements

Member Telehealth Consent: Ten 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

Service Authorizations: Four member files were reviewed for evidence of appropriate service authorization, including the concurrent review authorization process.

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

Category 6 – Member Rights and Protection

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

Appeal Procedures: Three 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 2 – Care Coordination and Continuity of Care

2.1 Coordination of Care Requirements

2.1.1 Care Coordination with Managed Care Plans

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 shall coordinate the services the Plan furnishes to the member with the services the member receives from any other managed care organization, in Fee-for-service 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); Code of Federal Regulations (CFR), Title 42, section 438.208(b)(2)(i)-(iv); California Code of Regulations (CCR), Title 9, section 1810.415)*

Plans shall coordinate member care services with MCPs to facilitate care transitions or addition of services, including ensuring that the referral process has been completed, the member has been connected with a provider in the new system, and the new provider accepts the care of the member, and medically necessary services have been made available to the member. *(BHIN 22-065 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services)*

Plan policy *Screening and Transition of Care (revised December 11, 2023)* stated the Plan shall coordinate member care services with MCPs to facilitate care transitions or addition of services, including ensuring that the referral process has been completed, the member has been connected with a provider in the new system, and the new provider accepts the care of the member, and medically necessary services have been made available to the member.

Plan's *Memorandum of Understanding (MOU) with Blue Cross of California Partnership Plan, Inc. and Health Net Community Solutions, Inc. (effective September 9, 2024)* stated the MCP and the Plan must use the required Transition of Care Tool to facilitate transitions of care for members when their service needs change. Provides referrals to MCP, and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the member has been connected with a

network provider who accepts their care and that services have been made available to the member.

Finding: The Plan did not coordinate member care services with MCPs to ensure medically necessary services were made available to members.

In a verification study, ten of ten samples revealed that there was no evidence of the Plan's coordination with MCPs to ensure the referral process has been completed, the member has been connected with a provider, the new provider accepted the care, and medically necessary services have been made available to the member.

The Plan submitted training materials. However, there was no evidence demonstrating that the Plan had training for the staff coordinating with the MCPs regarding the completion of MHP to MCP referrals.

In an interview, the Plan stated that there was a gap in knowledge that coordination with the MCPs was required after the referral was sent to ensure the completion of the referral process. Additionally, the Plan confirmed that there was no training to ensure the coordination and completion of referrals after they were sent to the MCPs.

When the Plan does not ensure coordination and completion of MCP referrals, it can result in missed or delayed medically necessary services for members.

Recommendation: Implement policies and procedures to ensure care coordination and completion of MCP referrals including medically necessary services are made available to members.

COMPLIANCE AUDIT FINDINGS

Category 4 – Access and Information Requirements

4.1 Language and Format Requirements

4.1.1 Braille Alternative Format

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))*

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, Exhibit E, Section. 6(H))*

Medi-Cal Behavioral Health delivery systems (Mental Health Plans, 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, *Access to Behavioral Health Service (approved January 17, 2019*) described the Plan's guideline that access is available to members with disabilities requiring assistance or communication for the visually or hearing impaired. The policy specifies alternative formats are available in audio CD and large print.

Finding: The Plan did not ensure that alternative format, braille, was available to its members.

Plan policy, *Access to Behavioral Health Service Policy,* addressed the provision of informing materials in alternative formats. However, the policy did not include procedures to ensure accessibility requirements for braille.

In an interview and written narrative, the Plan acknowledged that the policy lacked updates for alternative formats during the audit period. The Plan stated that if braille was requested by a member, the Plan would contact Tuolumne County's Social Services Department, which held a contract for braille services. The Plan stated that there is no documentation outlining this process and did not provide the requested contract.

When the Plan does not ensure that alternative format, braille, is available to members, it may not ensure consistent and accessible communication for members with disabilities. This limits members' access and prevents them from having adequate knowledge to make informed decisions. This may 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 format, braille, is available to members.

4.4 Specialty Mental Health Services Via Telehealth

4.4.1 Telehealth Consent 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))*

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; 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 policy, *Telehealth for Mental Health and Substance Use Disorder Treatment Services (revised September 26, 2023)* stated verbal or written informed consent for telehealth services will be obtained by the provider which includes the required elements in BHIN 23-018 and documented in the member chart.

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, ten of ten member records revealed that the consent forms were missing the required element that non-medical transportation benefits are available for in-person visits.

In an interview, the Plan stated that the telehealth consent form was developed by a subcontractor and adopted by the Plan. The Plan acknowledged the consent form template, which was reviewed by the audit team, lacked the required element regarding the availability of non-medical transportation for in-person visits. Although the Plan has policies and procedures, the Plan did not monitor the providers' consent documentation nor ensure that providers explained member benefits. Furthermore, the Plan stated that staff received telehealth training during onboarding.

The reviewed training material did not include the elements listed in BHIN 23-018, including the availability of non-medical transportation for in-person visits.

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.