DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SUBSTANCE USE DISORDER REVIEW SECTION

REPORT ON THE SUBSTANCE USE DISORDER (SUD) AUDIT OF TULARE COUNTY BEHAVIORAL HEALTH FISCAL YEAR 2024-25

Contract Number(s): 21-10036

Contract Type: Drug Medi-Cal Organized Delivery System (DMC-ODS)

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

Dates of Audit: September 10, 2024 — September 20, 2024

Report Issued: January 31, 2025

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I. INTRODUCTION

Tulare 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 substance use disorder services to county residents.

Tulare County is located in the Central Valley of California's San Joaquin Valley. The Plan provides services within the unincorporated county and in eight cities: Visalia, Tulare, Porterville, Three Rivers, Springville, Dinuba, Exeter, and Farmersville.

As of June 2024, the Plan had a total of 2,873 members receiving DMC-ODS services and a total of 37 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 September 10, 2024, through September 20, 2024. The audit consisted of documentation review and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on January 15, 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 January 22, 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 five categories of performance: Availability of Drug Medi-Cal Organized Delivery System (DMC-ODS) Services, Care Coordination and Continuity of Care, Access and Information Requirements, Coverage and Authorization of Services, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2022, through June 30, 2023, identified deficiencies incorporated in the Correction Action Plan (CAP). The prior year CAP was not completely closed at the time of onsite; however, this year's audit included a review of documents to determine the implementation and effectiveness of the Plan's corrective actions.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Availability of Drug Medi-Cal Organized Delivery System

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 4 – Access and Information Requirements

The Plan is required to provide interpretive services and make member information available in the following alternative formats: Braille, audio format, large print (no less than 20-point font), and accessible electronic format (such as a data CD). The Plan did not ensure the provision of communication materials in all required standard alternative formats, including braille and large print of at least 20-point font or larger.

The Plan is required to ensure all providers obtain and document members' consent prior to the initial delivery of covered services via telehealth. The Plan did not ensure a process to determine whether its providers are able to adequately perform subcontracted requirements to obtain consents for telehealth services.

Category 5 – Coverage and Authorization of Services

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 DMC-ODS Contract.

PROCEDURE

DHCS conducted an audit of the Plan from September 10, 2024, through September 20, 2024, 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 – Availability of Drug Medi-Cal Organized Delivery System Services

There were no verification studies conducted for the audit review.

Category 2 – Care Coordination and Continuity of Care

There were no verification studies conducted for the audit review.

Category 4 – Access and Information Requirements

There were no verification studies conducted for the audit review.

Category 5 – Coverage and Authorization of Services

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 4 – Access and Information Requirements

4.1 Language and Format Requirements

4.1.1 Alternative Format Documentation Requirements

The Plan is required to provide interpretive services and make member information available in the following alternative formats: braille, audio format, large print (no less than 20-point font), and accessible electronic format (such as a data CD). *(Contract, Amendment 1, Exhibit A, Attachment 1, Program Specifications, K, 6, iii)*

Plan policy, *04-005 Information Requirements V2 (effective 3/1/2024),* stated the Plan will provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills upon request and free of charge. The Plan shall also notify beneficiaries, prospective beneficiaries, and members of the public that these services are available free of charge and how to access these services. Medi-Cal behavioral health delivery systems must provide interpretive services and make member information available in the following alternative formats: braille, audio format, large print, and accessible electronic format (such as a data CD), as well as other auxiliary aids and services that may be appropriate.

Finding: The Plan did not ensure the provision of communication materials in all required standard alternative formats, including braille and large print of at least 20-point font or larger.

The Plan's policy *04-005 Information Requirements V2* provided did not specify that large print materials must be 20-point font or larger.

The Plan did not furnish documents to demonstrate compliance with the requirement of providing alternative communication in braille and large print of 20-point font or larger.

In an interview, the Plan stated there was no process in place for providing communication materials in braille.

In a written narrative, the Plan reiterated that staff was not aware of the requirement for large print to be a minimum font size of 20-point font.

When the Plan does not provide all required alternative formats of communication materials, it limits the member's access to information and may prevent them from having adequate knowledge to make informed decisions about their health care. This can result in poor health outcomes due to missed or delayed access to medically necessary behavioral health services.

Recommendation: Revise and implement policies and procedures to ensure provision of communication materials in all required standard alternative formats, including, braille and large print of at least 20-point font or larger.

4.4 Access Requirements

4.4.1 Telehealth 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 beneficiaries:

- The beneficiary 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 beneficiary's ability to access Medi-Cal covered services in the future.
- Non-medical transportation benefits are available for in-person visits.
- Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable. *(Behavioral Health Information Notice 23-018, Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal)*

Notwithstanding any relationship(s) that Contractor may have with any subcontractor, the Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Agreement. *(Plan Contract, Amendment 2, Exhibit A, Attachment 1, Program Specifications, E, 9, ii); (42 CFR section 438.230)*

Plan policy *10-16, Telehealth Services (10/01/2022)* stated members must provide consent verbally or in writing prior to initiating telehealth services and must be

documented in the member medical record. In addition, the consent must include the right to access covered services in person; telehealth is voluntary, members can withdraw consent at any time without affecting their ability to access covered services in the future; non-medical transportation services are available to in-person visits; and potentials limitation or risks of receiving services through telehealth compared to in person-visit.

Finding: The Plan did not ensure a process to determine whether its providers are able to adequately perform subcontracted requirements to obtain consents for telehealth services.

The Plan monitors its subcontractors using a utilization chart review tool. However, this utilization chart review tool showed that the Plan did not review provider compliance in obtaining and documenting verbal or written consent prior to the initial delivery of telehealth services.

Plan policy, *10-16* does not include a process for the Plan to ensure compliance with the requirement to obtain and document member consent for telehealth services.

In an interview, the Plan stated that clinicians document the telehealth consents in SmartCare and verbal consent can be documented in a progress note. The Plan stated member consent was not included in its chart utilization review tool, and it did not have a monitoring mechanism to ensure clinicians comply with the telehealth consent requirement. Member consent was not identified as an aspect of monitoring.

In a written narrative, the Plan reiterated there was no process in place for monitoring the completion of member consents.

When the Plan does not ensure all providers obtain and document members' consent prior to the initial delivery of covered services via telehealth, members are not fully informed about their options or rights related to telehealth services.

Recommendation: Revise and implement policies and procedures to ensure Plan providers meet the requirement to obtain verbal or written consent prior to the initial delivery of covered telehealth services.