DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

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

Contract Number: 22-20142

Contract Type: Specialty Mental Health Services

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

Dates of Audit: October 15, 2024 — October 25, 2024

Report Issued: March 26, 2025

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I. INTRODUCTION

Tehama 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.

Tehama County is located in the northern part of California. The Plan provides services within the unincorporated county and in the cities of Red Bluff and Corning.

As of November 2024, the Plan had a total of 2,105 members receiving services and a total of 57 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 October 15, 2024, through October 25, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on March 6, 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 March 7, 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 onsite. Therefore, this year's audit included a review of documents to ensure that its 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 – 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

The Plan is required to implement mechanisms to monitor the safety and effectives of medication practices. The Plan did not implement medication monitoring practices during the audit period.

The Plan is required to have practice guidelines that outline the requirements for authorization and utilization management of SMHS provided by the Plan. The Plan did not establish practice guidelines.

Category 4 – Access and Information Requirements

The Plan is required to provide members who are blind or visually impaired, and other individuals with disabilities, with communication materials in alternative formats. The Plan did not have a process to provide larger print format (20-point font), audio CD, Data CD, or braille to beneficiaries.

The Plan is required to ensure providers obtain and document the members' consent prior to the initial delivery of telehealth services and inform members that Non-Medical Transportation (NMT) services or any potential limitations or risks related to receiving covered services are available for in-person visits. The Plan did not ensure members received all required explanation elements before obtaining a telehealth consent.

Category 5 – Coverage and Authorization of Services

The Plan is required to operate a utilization management (UM) program that ensures beneficiaries have appropriate access to SMHS. The Plan did not implement the evaluation of medical necessity provided to beneficiaries through concurrent review authorization procedures.

Category 6 – Beneficiary Rights and Protection

The Plan is required to log within one business day and that members were sent written acknowledgement letters postmarked within five (5) calendar days of receipt of the grievance. The Plan did not ensure that grievances were logged within one business day and that members were sent written acknowledgement letters within five calendar days of receipt of grievance.

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 October 15, 2024, through October 25, 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 – 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: Five member referrals from the Managed Care Plan (MCP) to the Mental Health Plan (MHP) and ten 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

There were no verification studies conducted for the audit review.

Category 5 – Coverage and Authorization of Services

Authorizations: Ten 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: Ten grievances 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 3 – Quality Assurance and Performance Improvement

3.1 Quality Assessment and Performance Improvement Program Category

3.1.1 Medication Monitoring

The Plan shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense medication. Performed at least annually, and inclusive of medications prescribed to adults and youth. *(Contract, Exhibit A, Attachment 5, section 1(H))*

Finding: The Plan did not implement medication monitoring practices during the audit period.

The Plan does not have a policy that outlines its process for overseeing its medication monitoring practices.

In an interview, the Plan reported that no medication monitoring was performed during the audit period. The Plan stated that it attempted to contract with a local organization to secure a psychiatrist for medication monitoring activities, but these efforts were unsuccessful. The Plan's interview statement was confirmed since the Plan submitted a medication monitoring contract agreement that was executed after the audit period.

When the Plan does not provide medication monitoring, beneficiaries may experience gaps in medication safety, potentially affecting treatment outcomes.

This is Repeat Finding of the 2020-2021 audit finding – Quality Assurance and Performance Improvement

Recommendation: Develop and implement policies and procedures to establish a consistent oversight structure for medication monitoring conducted by person licensed to prescribe or dispense medication.

3.5 Practice Guidelines

3.5.1 Implementation of Practice Guidelines

The Plan has practice guidelines, which meet the requirements of the Plan contract. *(Contract, Exhibit A, Attachment 5, section 6(A); California Code of Regulations (CCR), Title 9, section 1810.326)*

Practice guidelines shall meet the following requirements: they are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field; they consider the needs of the beneficiaries; they are adopted in consultation with network providers; and they are reviewed and updated periodically as appropriate. *(Code of Federal Regulations (CFR), Title. 42, section 438.236(b))*

Finding: The Plan did not ensure that practice guidelines were implemented during the audit period.

Review of Plan documents showed that the Plan lacked policies to establish and implement practice guidelines. Additionally, the Plan did not submit evidence of practice guidelines.

In an interview, the Plan explained that the absence of practice guidelines was due to delays attributed to staffing challenges. The Plan reported ongoing efforts to recruit for vacant positions necessary to oversee the establishment of practice guidelines.

As a corrective action plan (CAP) to the 2020-2021 audit finding (Quality Assurance and Performance Improvement), the Plan proposed to complete policies and procedures for dissemination of the MHP Practice guidelines. In a narrative, the Plan reported long-standing vacancies in key-roles, including the Mental Health Director and Quality Assurance Manager, which impacted oversight of policy updates and practice guidelines. This staffing shortage, along with a high agency turnover rate, further delayed the establishment of practice guidelines. Review of the Organizational Chart confirmed staff vacancies as reported by the Plan.

When the Plan does not ensure availability of practice guidelines, beneficiaries and providers may not be aware of specific treatments available within the Plan, potentially impacting the quality and effectiveness of treatment.

This is Repeat Finding of the 2020-2021 audit finding – Quality Assurance and Performance Improvement

Recommendation: Develop and implement practice guidelines.

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 applicable requirements of federal and state disability law and take appropriate steps to ensure effective communication with individuals with disabilities. *(Contract, Exhibit A, Attachment 11, section 1(A); 42 CFR section 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 individuals' requested alternative formats. The standard alternative formats options are large print (20 Point), audio CD, Data CD, and Braille. *(BHIN 24-007; Effective Communication, Including Alternative Formats, for individuals with Disabilities, (Jan. 2024), p.2, 5.); BHIN 23-048: Annual Update – Mental Health Plan and Drug Medi-Cal Organized Delivery System Beneficiary Handbook Requirements and Templets; Enclosure 1: MHP Beneficiary Handbook, pg. 6*

Plan policy *03-01-1190, Translated Materials/Alternative Formats (revised 5/1/2018)* stated the Plan will provide alternative formats and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. The policy also describes the forms that are available in threshold languages(s), written in font no smaller than 12 points, available in large print (18-point front minimum), available in alternative formats (e.g. audio), use easily understood language and format (e.g. 6th grade reading level), taglines, TTY/YDY, and including information on how to access the forms.

Finding: The Plan did not ensure that alternative communication material was available to its members, including large print 20-point font format, audit CD, Data CD, and braille.

Review of Plan documents did not show a clear process of who is responsible for providing alternative format materials upon member request.

In an interview, the Plan stated that the update process is ongoing, including adjustments to materials in 20-point font. A braille printer has been purchased but is not yet fully implemented. Audio CDs and Data CDs are also in process but not finalized. The omission of new requirements in its current policy, information materials, and forms is due to current vacant Quality Assurance Manager position which has oversight of these efforts.

Following the interview the Plan did not submit evidence of contract compliance in providing alternative formats of communication, including large print 20-point font format, audio CD, Data CD, and braille to beneficiaries.

When the Plan does not provide alternative formats to beneficiaries, 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: The Plan shall develop and implement policies and procedures to ensure alternative formats are available to beneficiaries upon request.

4.4 Telehealth Beneficiary Consent

4.4.1 Obtaining Verbal or Written Consent for Telehealth Services

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. *(BHIN 23-018, Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal)*

Plan policy *03-07-155, Telepsychiatry Services (revised 10/10/2014)* outlined the requirement to obtain and document consent for telepsychiatry services; the consent must state the beneficiary has decided to receive telepsychiatry services, which is documented in the chart.

Finding: The Plan did not ensure members received all required explanation elements before obtaining a telehealth consent.

Review of the Plan's telehealth consent form revealed that it included certain required explanation elements except for the following topics:

- 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

Although Plan policy 03-07-155 outlined the requirements to obtain and document consent for telepsychiatry services, this policy did not state that the Plan will ensure members receive all elements of required explanations prior to obtaining the telehealth consent.

In an interview, the Plan acknowledged that its current consent form and consent policies and procedures are out of date and do not address the need to explain to members about the availability of non-medical transportation for in-person visits or potential limitations and risks associated with receiving services via telehealth.

When the Plan fails to explain both the benefits and risks before obtaining consent, members are not fully informed about their options, rights, or alternatives related to telehealth services.

Recommendation: Revise and implement policies and procedures, to ensure members received all required explanation elements before obtaining a telehealth consent. Update the telehealth policy and consent form to explicitly include all required elements, such as the member's right to access in-person services, the voluntary nature of telehealth, the option to withdraw consent without affecting future access to Medi-Cal services, NMT benefits, and any potential limitations or risks of telehealth compared to in-person visits.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.2 Concurrent Review and Prior Authorization Requirements

5.2.1 Concurrent Authorization Review

The Plan is required to operate a utilization management (UM) program that ensures beneficiaries have appropriate access to specialty mental health services (SMHS). The UM program must evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries 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; CCR Title 9, section 1810.44(b); CFR Title 42, section 438.210(a)(4), (b)(1), (2))*

Finding: The Plan did not conduct concurrent authorization review procedures for psychiatric inpatient hospital services to its members.

A verification study of TAR documentation for clients hospitalized in psychiatric facilities during the audit period revealed that ten of the ten client files were processed after-discharge, rather than as part of an ongoing concurrent review. This practice did not align with concurrent review processes needed to assess medical necessity and appropriateness during beneficiary inpatient stays.

In an interview, the Plan acknowledged the concurrent review processes were not fully implemented in a way that allows for review, modification, or denial of services while clients are hospitalized. The Plan stated it has worked to establish infrastructure for concurrent review; however, the Plan's high turnover and difficulties in securing qualified staff created barriers to implement the process specifically the absence of a Quality Assurance Manager. This shortage of expertise lead to inadequate oversight of quality assurance activities, which increased the risk of non-compliance and compromised the integrity of the evaluation process for medical necessity.

In a narrative the Plan indicated that its Medical Coordination Team (MCT) monitored inpatient clients once or twice per week along with coordinating with its Behavioral Health Clinical Team to determine client needs; however, this is not indicative of a concurrent review process.

When the Plan does not ensure concurrent review, beneficiaries may experience delays in identifying their care needs and coordinating necessary services, potentially leading to extended hospital stays.

Recommendation: Establish a structured concurrent review process to ensure required evaluation of medical necessity, appropriateness, and efficiency of services provided to Medi-Cal beneficiaries.

COMPLIANCE AUDIT FINDINGS

Category 6 – Beneficiary Rights and Protection

6.1 Grievance and Appeal System Requirements

6.1.1 Grievance Log and Acknowledgement Letter Timeliness for Grievances

The Plan shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. *(Contract, Exhibit A, Attachment 12, section 1(B)(5))*

The acknowledgement letter shall include the date of receipt, name of representative to contact, telephone number of contract representative and address of Plan. The written acknowledgment to the beneficiary must be postmarked within (5) calendar days of receipt of the grievance. *(Mental Health and Substance Use Disorder Services Information Notice (MHSUDS IN) 18-010E, Federal Grievance and Appeal System Requirements with Revised Beneficiary Notice Templates)*

Maintain a grievance and appeal log and record grievance, appeals, and expedited appeals in the log within one business day of the date of receipt of the grievance, appeal, or expedited appeal. *(Contract, Exhibit A, Attachment 12, section 2(A))*

Plan policy *Problem Resolution, Grievance, and Appeal Process: Medi-Cal Beneficiaries (revised 2/22/2023)* outlines procedures for managing grievances and appeals. The policy specified that the Quality Assurance Manager (QAM) is responsible for ensuring and appeals are logged within one business day and that acknowledgement letter are sent and postmarked within five calendar days or receipt.

Finding: The Plan did not ensure that grievances were logged within one business day and that members were sent written acknowledgment letters within five calendar days of receipt of grievance.

A verification study revealed that the Plan did not implement its policies and procedures for logging grievances and sending acknowledgment letters in a timely manner.

- Five of ten grievances were not logged within one business day of receipt. Rather, the grievances were logged between a duration of two through 29 days after receipt.
- Four of ten acknowledgement letters were postmarked beyond the five-day requirement, two of which were missing and could not be located by the Plan and two acknowledgment letters were sent between six and 21 days of receipt.

In an interview, the Plan explained that grievance processing responsibility was shared between the Compliance Officer and Assistant Executive Director during half a year absence of the QAM. Schedules were coordinated to have at least one person available to manage sending of acknowledgement letters and logging of grievances. Despite the coordination efforts, high workloads and competing work priorities impacted the Plan's ability to consistently meet the required acknowledgement and logging timelines.

In a narrative, the Plan stated that staffing shortages and the volume of tasks assigned to staff covering multiple roles, contributed to recurring delays in grievance acknowledgement and logging processes. The length of absence of a designated QAM and grievance staff affected the Plan's ability to comply with grievance acknowledgement and logging requirements.

When the Plan does not ensure adherence to the timeliness of properly logging grievances within one business day of the date of receipt or sending written acknowledgment letters within five calendar days of receipt of grievance can result in beneficiaries not knowing if a grievance is being reviewed by the Plan in a timely manner.

This is Repeat Finding of the 2020-2021 audit finding – Beneficiary Rights and Protection

Recommendation: Ensure consistent oversight of grievance processing by designating a primary staff member responsible for maintaining a grievance log and timely acknowledgement of grievances.