DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SUBSTANCE USE DISORDER REVIEW SECTION

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

Contract Number: 20-10204

Drug Medi-Cal (DMC)

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

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

Report Issued: March 26, 2025

TABLE OF CONTENTS

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 substance use disorder 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 841 members receiving services and a total of 15 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 six categories of performance: Availability of Drug Medi-Cal Services (DMC), Quality Assurance and Performance Improvement, Access and Information Requirements, Beneficiary Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2021, through June 30, 2022, 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 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 Services

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

Category 3 – Quality Assurance and Performance Improvement

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

Category 4 – Access and Information Requirements

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

The Plan is required to have an affirmative responsibility to obtain member consent prior to initial delivery of covered service via telehealth. The Plan did not ensure that all providers obtained and documented verbal or written consent from members prior to the initial delivery of covered services via telehealth.

Category 6 – Beneficiary 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 DMC 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 – Availability of Drug Medi-Cal Services

There were no verification studies conducted for the audit review.

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

There were no verification studies conducted for the audit review.

Category 6 – Beneficiary 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 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. I, Part II, sec. S(6)(a))*

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 format 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*

Plan policy, *03-07-1175 American Sign Language (ASL) Interpreters (issued 10/14/11)*, stated that anytime a client with hearing impairment that communicates with ASL is to be seen, an interpreter will be requested. This includes face-to-face assessments, ongoing therapy, medication support, etc. The policy states that the Plan utilizes NorCal Services for deaf and hard of hearing and California Relay Services to provide services for hearing impaired Members.

Plan Policy, *American with Disabilities Act Compliance Policy (issued 3/29/2018),* outlined procedures to ensure compliance with the Americans with Disabilities Act (ADA) and addresses language barriers, specifically, language interpretation for the hearing impaired made available through the California Services which provides TDD to Voice and Voice English to TDD. Language interpretation for the hearing impaired is also addressed through face-to-face interpretation.

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

The Plan lacks policies and procedures to ensure that alternative communication material was available to its members, including large print 20-point font format, audit CD, Data CD, and braille.

In an interview, the Plan stated that they did not have the staffing needed to implement the items required per BHIN 24-007 and update policies and procedures.

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 ensure communication materials are available in all required alternative formats, the ability for members who are blind, visually impaired or with other disabilities to receive information regarding medically necessary treatment services can be negatively impacted.

Recommendation: The Plan shall develop and implement policies and procedures to ensure alternative formats are available to beneficiaries upon request.

4.2 Telehealth Requirements

4.2.1 Telehealth Member Consent

The Plan has an affirmative responsibility to obtain beneficiary 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; 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, (April 2023))*.

Finding: The Plan did not ensure that all providers obtain verbal or written member consent from beneficiaries prior to the initial delivery of covered services via telehealth.

In an interview, the Plan stated that it did not have written policies and procedures and a consent form to reflect the requirements of BHIN 23-018 due to the absence of the Quality Assurance Manager, which has resulted in gaps in oversight and communication regarding the consent process. Consequently, this has resulted in unclear expectations for obtaining and documenting consent before delivering services.

The Plan did not furnish documentation that demonstrates the Plan, or subcontracted providers obtain verbal or written consent for the use of telehealth.

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: Develop and implement policies and procedures to ensure the Plan obtains members' consent prior to the initial delivery of covered services via telehealth.