DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

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

Contract Number: 23-30098

Contract Type: Drug Medi-Cal (DMC)

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

Dates of Audit: May 12, 2025 — May 23, 2025

Report Issued: October 23, 2025

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I. INTRODUCTION

Plumas 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 substance use disorder services to county residents.

Plumas County is located in the Sierra Nevada of California. The Plan provides services within the unincorporated county and in Portola City, including Quincy, the unincorporated county seat.

As of June 2024, the Plan had a total of 30 Medi-Cal members receiving Drug Medi-Cal (DMC) services and a total of 2 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 May 12, 2025, through May 23, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on October 3, 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 October 21, 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 DMC Services, 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, 2022, through June 30, 2023, identified deficiencies incorporated in the Corrective Action Plan. The prior year Corrective Action Plan 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.

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

The summary of the findings by category is as follows:

Category 1 – Availability of Drug Medi-Cal Services

The Plan must require all subcontractors to inform the Plan when a member who resides in the Plan's county is referred to and served by an out-of-county provider. Finding 1.1.1: The Plan did not require its subcontractors to notify the Plan when a member is referred to and served by an out-of-county provider.

Category 3 – Quality Assurance and Performance Improvement

The Plan is required to monitor its providers monthly to ensure they maintain active enrollment in the DMC program. Finding 3.1.1: The Plan did not monitor its providers monthly 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. Finding 4.1.5: The Plan did not ensure the alternative communication material in braille was available to its members.

The Plan is required to obtain verbal or written consent prior to initial delivery of covered services via telehealth. Finding 4.2.1: The Plan did not ensure providers obtained either 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 May 12, 2025, through May 23, 2025, 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 the Plan's representatives.

The following verification studies were conducted:

Category 1 – Availability of Drug Medi-Cal Services

Subcontracted Provider: Three subcontracted providers were reviewed to ensure all medical necessity for substance use disorder treatment services were provided to members.

Category 3 – Quality Assurance and Performance Improvement

There were no verification studies conducted for the audit review.

Category 4 – Access and Information Requirements

Telehealth Services: Nine member files were reviewed to ensure providers obtained verbal or written consent for the use of telehealth services.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: One grievance was 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 1 – Availability of Drug Medi-Cal Services

1.1. Availability of Drug Medi-Cal Services

1.1.1 Subcontractor's Plan Notification

The Plan must require all subcontractors to inform the Plan when a member that resides in the Plan's county is referred to and served by an out-of-county provider. *(Contract 23-30098, Exhibit A, Attachment I, Part I, Section 3(A)(9))*

The Plan's subcontracts require all subcontractors to comply with the requirements of *Exhibit A, Attachment I, Part I, Section 3*. *(Contract 23-30098, Exhibit B, Part IV, Section 1(A)(5))*

Plan policy, *801.3 Provider Contract Development and Monitoring* (approved 12/16/2023), outlined the standards and activities related to the development and monitoring of the Plan's contracts, including the Plan's required components for contracting subcontractors.

Finding: The Plan did not require its subcontractors to notify the Plan when a member is referred to and served by an out-of-county provider.

Although Plan policy *801.3* outlined the standards and activities related to the development and monitoring of the Plan's contracts, including the Plan's required components for contracting subcontractors, it does not include language informing subcontractors that they must inform the Plan when members are referred to or served by an out-of-county provider.

A review of the Plan's three subcontract agreements found that all agreements did not include language requiring the subcontractor to inform the Plan when their members were referred to an out-of-county provider.

During the interview, the Plan confirmed that the requirement is not part of the Plan's policy. The Plan also mentioned that if members needed additional services, the subcontractor would notify them via email or phone call. However, the Plan did not provide evidence to substantiate this statement.

When the Plan does not ensure subcontractors notify the Plan when a member is referred to and served by an out-of-county provider, members may experience gaps in continuity of care.

Recommendation: Develop and implement policies and procedures to ensure subcontractors notify the Plan when a member is referred to and served by an out-of-county provider.

COMPLIANCE AUDIT FINDINGS

Category 3 – Quality Assurance and Performance Improvement

3.1 Monitoring

3.1.1 Monitoring for Active Provider Enrollment

The Plan is required to monitor their providers monthly to ensure they maintain active enrollment in the DMC program. *(Contract 23-30098, Exhibit A, Attachment I, Part I, Section 6(B)(2)(a))*

Plan policy, *801.3 Provider Contract Development and Monitoring* (approved 12/16/2023), outlined the standards and activities related to the development and monitoring of the Plan's contracts, including the contract oversight and monitoring.

Finding: The Plan did not monitor its providers monthly to ensure they maintain active enrollment in the DMC program.

Although Plan policy *801.3* included the standards and activities related to the development and monitoring of the Plan's compliance with contracts requirements, this policy does not include procedures to conduct monthly monitoring of provider enrollment in the DMC program.

During the interview, the Plan stated they utilize email communication to monitor DMC program provider enrollment. However, a review revealed they did not consistently monitor enrollment for several months in 2023 and 2024. In a written statement, the Plan acknowledged this oversight was due to prioritizing other administrative obligations.

When the Plan does not monitor its providers monthly to ensure they maintain active DMC certification, members may experience harm or legal liability if services are delivered by a provider who is no longer authorized or credentialed.

Recommendation: Develop and implement policies and procedures to monitor providers monthly to ensure they maintain active enrollment in the DMC program.

COMPLIANCE AUDIT FINDINGS

Category 4 – Access and Information Requirements

4.1 Language and Format Requirements

4.1.5 Member Materials in Braille

The Plan is required to comply with all state and federal statutes and regulations, the terms of this agreement, Behavioral Health Information Notices (BHIN), and any other applicable authorities. *(Contract 23-30098, Exhibit A, Attachment I, Part 1, Section 1(B))*

The Plan is required to provide a member who is blind or visually impaired with communication materials in alternate formats that include Braille. *(BHIN 24-007, Effective Communication, Including Alternative Formats, for Individuals with Disabilities)*

Plan policy, *100.20 Cultural and Linguistic Services* (revised 10/30/2023), stated that services will be made available to all eligible members in a culture language that is preferred by the member. If needed, an audio version of the materials will be provided. Plan staff may also be available to read material to the member The policy also includes a procedure on how to obtain an interpreter and bilingual services.

Finding: The Plan did not ensure that alternative communication material in braille was available to its members.

The Plan's policy does not include procedures for providing members who are blind or visually impaired with communication materials in alternate formats, including Braille.

During the interview, the Plan stated that they have not looked into providing materials in Braille. In a written response, the Plan indicated that Braille materials are available upon request and will be provided to the member within ten business days, which conflicts with what was stated during the interview. However, the Plan did not provide supporting documentation, such as contracts or procedures, to show how the Plan will provide Braille materials within ten business days.

When the Plan does not provide alternative formats to members, such as braille, it limits the member's accessibility, therefore preventing the member 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: Revise and implement policies and procedures to ensure the availability of the braille format as an alternative communication material to members.

4.2 Access Requirements

4.2.1 Consent of Telehealth Services

The Plan is required to comply with all state and federal statutes and regulations, the terms of this agreement, BHINs, and any other applicable authorities. *(Contract 23-30098, Exhibit A, Attachment I, Part 1, Section 1(B))*

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.
- 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, *300.3 Consent to Treatment and Confidentiality* (revised 01/04/2023), stated that verbal or written consent must be obtained before using telehealth to deliver services.

Plan policy, *702.3 Documentation Requirements for all SMHS, DMC, and DMC-ODS Services* (revised 12/19/2023), stated that, when a visit is provided via telehealth, the health care provider must confirm the member's consent for telehealth services, either in writing or verbally, at least once prior to initiating applicable services. The provider must also explain that covered telehealth services are available through in-person visits; that the use of telehealth is voluntary, and consent may be withdrawn at any time without affecting future access to covered services; and that Medi-Cal covers transportation to in-person visits. The provider must document in the medical record the provision of this information and the member's verbal or written acknowledgment that the information was received.

Finding: The Plan did not ensure that providers obtained either verbal or written consent, including all required consent elements, before providing telehealth services.

In a verification study, four of nine samples did not meet telehealth consent requirements:

- Three samples did not include a member consent for telehealth services.
- One sample did not contain all the required consent elements. While it acknowledged that the member had been informed of the risks inherent in telehealth compared to in-person care, it did not address other required elements, such as the option to receive in-person care, the availability of transportation to access in-person care, and the member's right to revoke consent for telehealth services.

During the interview, the Plan explained that they did not have telehealth providers until the end of 2023. An internal audit later revealed issues related to obtaining consent for telehealth services, prompting changes in the intake process. Although a checklist was introduced to document consent during intake, the Plan acknowledged that there are still ongoing challenges in training providers to obtain/secure signed telehealth consent forms.

When the Plan does not obtain telehealth consent, whether verbal or written, prior to the initial provision of covered services, it may constitute a breach of member rights and elevate the risk that individuals are not adequately informed or involved in decisions concerning their care.

Recommendation: Revise and implement policies and procedures to ensure that providers obtain either verbal or written consent, including all required consent elements, before providing telehealth services.