DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

RANCHO CUCAMONGA SECTION

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

Contract Number: 22-20127

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2024 — June 30, 2025

Dates of Audit: September 9, 2025 — September 19, 2025

Report Issued: January 22, 2026

TABLE OF CONTENTS

I. INTRODUCTION

San Bernardino County Department of 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.

The Plan is the largest county in the contiguous United States, located in San Bernardino, California. The Plan provides services within twenty-four incorporated cities: Adelanto, Apple Valley, Barstow, Big Bear Lake, Chino, Chino Hills, Colton, Fontana, Grand Terrace, Hesperia, Highland, Loma Linda, Montclair, Needles, Ontario, Rancho Cucamonga, Redlands, Rialto, San Bernardino, Twentynine Palms, Upland, Victorville, Yucaipa, and Yucca Valley.

As of September 2025, the Plan had a total of 4,906 members receiving services and a total of 1,549 active providers.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2024, through June 30, 2025. The audit was conducted from September 9, 2025, through September 19, 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 December 30, 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 14, 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, Beneficiary 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 onsite.

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 the services it provides to the member with those the member receives from any other managed care organizations, ensuring the referral loop is closed by confirming that the new provider accepts the member's care and that medically necessary services are made available to the member. The Plan did not coordinate care with Managed Care Plans (MCPs) to ensure the referral loop was closed by confirming that medically necessary services were made available to the members. Finding 2.1.1: The Plan did not coordinate care with MCPs to ensure the referral loop was closed by confirming medically necessary services were made available to members.

Category 4 – Access and Information Requirements

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

Category 5 – Coverage and Authorization of Services

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

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 Specialty Mental Health Services (SMHS) Contract.

PROCEDURE

DHCS conducted an audit of the Plan from September 9, 2025, through September 19, 2025, for the audit period of July 1, 2024, through June 30, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. 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 mobile crisis services were reviewed for compliance with applicable federal and state regulations, program requirements and contractual obligations.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Ten member files were reviewed for evidence of referrals from a MCP to Mental Health Plan (MHP), and ten member referrals from MHP to MCP were reviewed for evidence of coordination of care.

Category 4 – Access and Information Requirements

Telehealth Services: Ten telehealth services were reviewed for compliance with applicable federal and state regulations, program requirements and contractual obligations.

Category 5 – Coverage and Authorization of Services

Authorizations: Thirteen Treatment Authorization Requests, five Crisis Residential Treatments, and five Adult Residential Treatment Authorization requests were reviewed for evidence of an appropriate authorization treatment process, including the concurrent review process.

Category 6 – Beneficiary Rights and Protection

Grievance and Appeals: Twelve grievances of quality of service, three grievances of quality of care, and four appeals were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for review.

Category 7 – Program Integrity

There was no verification study conducted for the audit review.

COMPLIANCE AUDIT FINDINGS

Category 2 – Care Coordination and Continuity of Care

2.1 Bidirectional Referral Care Coordination

2.1.1 Managed Care Plan Referral Care Coordination

The Plan shall coordinate the services it furnishes to the member with the services the member receives from any other managed care organization. (*Contract A1, Exhibit A, Attachment 10, Section 1(A)(2)*)

The Plan agrees to comply with all applicable federal and state law, as well as federal waivers, and Behavioral Health Information Notices (BHINs). (*Contract A1, Exhibit E, Section 6(B)*)

The Plan must coordinate with MCPs to facilitate care transitions and guide referrals for members receiving SMHS to transition to a Non-Specialty Mental Health Services (NSMHS) provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. (*BHIN 22-011 No Wrong Door for Mental Health Services Policy*)

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. (*BHIN 22-065 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services*)

Plan policy, *QM6055 No Wrong Door for Mental Health Services Policy* (effective 07/01/2022), describes concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between MCPs and MHPs to ensure member choice. MHPs must coordinate with MCPs to facilitate care transitions and guide referrals for members receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member.

Plan policy, *QM6059 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services* (effective 01/01/2023), describes that MHPs 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.

Finding: The Plan did not coordinate care with MCPs to ensure the referral loop was closed by confirming medically necessary services were made available to members.

Plan's policy QM6059 stated MHPs shall coordinate member care services with MCPs, ensuring the referral process has been completed and medically necessary services have been made available to the member. However, the Plan did not ensure that the referral process was completed and medically necessary services were made available to the member.

In a verification study, nine out of ten samples demonstrated that the Plan referred members to the MCP, but there was no evidence that the member received behavioral health services. Also, there is no documentation that the Plan reached out to the MCP to ensure medically necessary services were made available to the members.

In an interview, the Plan stated that after a member was referred to the MCP by the Plan, they do not request follow-up documentation to ensure that the member has been connected with the MCP. The Plan explained that once they have referred a member to the MCP, their understanding is that they have fulfilled their care coordination responsibilities. However, BHIN 22-065 states that the member needs to be 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.

When the referral process is not completed and the loop is not closed, members may not receive medically necessary services. This can lead to delays in care and gaps in treatment. These issues can increase the risk of worsening mental health conditions and may result in avoidable emergency room visits or hospitalizations.

Recommendation: Implement policies and procedures to coordinate care with MCPs to ensure the referral loop is closed by following up and confirming medically necessary services are made available to members.