DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

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

Contract Number(s): 22-20114

Contract Type: Specialty Mental Health Services

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

Dates of Audit: June 2, 2025 — June 20, 2025

Report Issued: October 15, 2025

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I. INTRODUCTION

Mendocino 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.

Mendocino County is located on the North Coast of California. The Plan provides services within the unincorporated county and in the cities of Fort Bragg, Point Arena, Ukiah, and Willits.

As of June 2025, the Plan had a total of 2,406 members receiving services and a total of 211 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 June 2, 2025, through June 20, 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 September 29, 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 September 29, 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: 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, 2018, through June 30, 2021, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP 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.

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 4 – Access and Information Requirements

The Plan is required to obtain member consent including criteria outlined in Behavioral Health Information Notice (BHIN) 23-018 prior to initial delivery of covered services via telehealth. Finding 4.4.1: The Plan did not ensure all providers obtained member consent, including criteria outlined in BHIN 23-018, prior to initial delivery of covered services via telehealth.

Category 5 – Coverage and Authorization of Services

The Plan is required to operate a utilization management (UM) program that evaluates medical necessity, appropriateness, and efficiency of services provided to Medi-Cal members prospectively, such as through prior or concurrent authorization review and authorization for administrative day services claims. Finding 5.2.1: The Plan did not implement a UM program that ensures its subcontractor evaluated and authorized administrative day service claims for psychiatric inpatient services.

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 Contract.

PROCEDURE

DHCS conducted an audit of the Plan from June 2, 2025, through June 20, 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 – 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: Ten 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 MCP and MHP.

Category 4 – Access and Information Requirements

Telehealth Consent Requirements: Ten member samples were reviewed for evidence of documentation of oral or written telehealth consent prior to the initial delivery of telehealth services.

Category 5 – Coverage and Authorization of Services

Service Authorizations: Ten member files were reviewed for evidence of appropriate service authorization request.

Treatment Authorizations: Ten member files were reviewed for evidence of appropriate treatment authorization including the concurrent review authorization process.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: One grievance of quality of care, and nine grievances of quality of service 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 4 – Access and Information Requirements

4.4 Telehealth Requirements

4.4.1 Telehealth Consent Form

The Plan is required to comply with all state and federal statutes and regulations, the terms of the contract, with BHINs, and any other applicable authorities. *(Contract, Exhibit E, section (6)(H))*

The Plan may delegate duties and obligations to subcontracting entities if the Plan determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. The Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the DHCS, notwithstanding any relationship(s) that the Plan may have with any subcontractor. *(Contract, Exhibit A, Attachment 1, section 3; Title 42 of Code of Federal Regulations (CFR) section 438.230(b)(1))*

The Plan has an affirmative responsibility to obtain member 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 criteria 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.

Providers must document the member's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. A provider may utilize a general consent agreement to meet this documentation requirement if that general consent agreement specifically mentions the use of telehealth delivery of covered services; includes the information described in BHIN 23-018; is completed prior to initial

delivery of services; and is included in the member record. *(BHIN 23-018, Updated Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal)*

Plan policy *No. II.D-9M, Telehealth/Telepsychiatry Services (revised May 2023)* stated that prior to delivery of telehealth services, providers shall obtain verbal or written telehealth consent which includes the required elements in BHIN 23-018, and the consent shall be documented in the member's medical record.

Plan procedure *Telehealth Monitoring and Tracking Procedures (created June 2023)* stated that for all members who consented to receive telehealth services, the Plan's Quality Assurance/Performance Improvement (QAPI) Team will track and verify that either a consent form was signed, or verbal consent was appropriately documented in the member's electronic health record.

Finding: The Plan did not ensure all providers obtained member telehealth consents that include all required elements.

Plan policy *No. II.D-9M, Telehealth/Telepsychiatry Services (revised May 2023)* required the subcontracted providers to obtain telehealth consent, and the Plan procedure *Telehealth Monitoring and Tracking Procedures (created June 2023)* established a tracking process for telehealth consents; the process did not ensure member consent included criteria outlined in BHIN 23-018.

In a verification study, four out of ten consent forms lacked documentation of the required elements outlined in BHIN 23-018.

In an interview and in a written narrative, the Plan stated that it had allowed providers to develop and implement telehealth forms if the forms were in compliance with BHIN 23-018. Providers were required to send documentation of telehealth consents to the Plan, which the QAPI Team would track on its monitoring log.

The subcontractor had used an outdated telehealth consent form that was implemented prior to the mandate to include criteria outlined in BHIN 23-018. The Plan acknowledged that its monitoring process did not detect the subcontractor's deficient telehealth consent forms. The Plan allowed providers to create telehealth forms following BHIN 23-018, and required them to submit telehealth consent documentation, which was tracked by the QAPI Team. However, the monitoring process failed to identify the subcontractor's inadequate consent forms, as the tool only confirmed that consent was obtained without verifying the necessary elements specific to BHIN 23-018.

When the Plan does not ensure that all providers are appropriately obtaining and documenting verbal or written telehealth consent before rendering telehealth services to members, it can result in members making poor health decisions due to a lack of adequate knowledge about treatment options.

Recommendation: Implement policies and procedures to ensure all providers obtain consent to all required telehealth criteria prior to the initial delivery of covered services via telehealth.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.2 Concurrent Review of Services

5.2.1 Authorizing Administrative Days

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, Exhibit E, section 6(H))*

The Plan's UM Program must evaluate medical necessity, appropriateness, and efficiency of services provided to Medi-Cal members prospectively, such as through prior or concurrent authorization review procedures. The concurrent review authorization process applies to all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals, and psychiatric health facilities (PHFs) certified by DHCS as Medi-Cal providers of inpatient hospital services. *(BHIN 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facilities Services)*

A hospital may claim for administrative day services when a member no longer meets medical necessity for acute psychiatric hospital services but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area. In order to conduct concurrent review and authorization for administrative day services claims, the Plan shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the member is placed on administrative day status. Once five contacts have been made and documented, any remaining days with the seven-consecutive-day period from the day the member is placed on administrative day status can be authorized. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented. Once the five-contract requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented. *(BHIN 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services)*

The Plan may delegate duties and obligations to subcontracting entities if the Plan determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. The Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the Department, notwithstanding any relationship(s) that the Plan may have with any subcontractor. *(Contract, Exhibit A, Attachment 1, section 3; 42 CFR section 438.230(b)(1))*

Plan contract *23-123, County of Mendocino Standard Services Agreement (7/1/2023-6/30/2024)* established the subcontractor as the Plan's delegate, providing delegated administrative program services, including adherence to the Plan's contract for initial, continuing, and concurrent authorization of services.

Plan policy *IV.C-1M, Point of Authorization (revised 02/2022)* outlined the delegate's responsibilities to conduct concurrent review and authorize administrative day claims for inpatient services after verifying documentation of contact attempts to non-acute residential treatment facilities.

Finding: The Plan's UM program did not ensure that its delegate, subcontractor, evaluated and authorized administrative day services claims for psychiatric inpatient services.

In a verification study, seven of ten administrative day authorization requests were denied reimbursement without documentation of criteria used for denials. The Plan did not provide request documentation of correspondence, records, or logs of hospital contact attempts to transfer members to non-acute facilities for any of the seven denied administrative day reimbursements.

In an interview, the Plan stated it had a process for communication and technical assistance to support the subcontractor when issues with inpatient authorization requests arose; however, the Plan acknowledged that the subcontractor would initiate the technical assistance, and administrative day claims had not been discussed. Additionally, the Plan stated that it did not hold meetings or training with the subcontractor to ensure compliance with administrative day authorization and documentation requirements during the audit period.

Furthermore, the Plan stated that all inpatient authorizations are conducted by its subcontractor. The Plan acknowledged that it did not have a system of oversight to ensure the subcontractor approved inpatient authorization requests in compliance with administrative day requirements. The lack of the Plan, monitoring, or quality review of

subcontractor authorization contributed to the denial of administrative day reimbursement without review of relevant supporting documentation.

When the Plan does not conduct oversight to ensure its delegate adequately authorizes UM requirements. The subcontractor cannot evaluate the medical necessity and appropriateness of authorized administrative day services claims for psychiatric inpatient services.

Recommendation: Implement policy and procedures to ensure its subcontractors review administrative day claims in compliance with BHIN 22-017.