DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

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

Contract Number: 22-20123

Contract Type: Specialty Mental Health Services

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 mental health 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 281 Medi-Cal members receiving Specialty Mental Health Services (SMHS) and a total of 5 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 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, Members Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period July 1, 2018, through June 30, 2021, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was completely 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 – 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

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

Category 4 – Access and Information Requirements

The Plan is required to obtain verbal or written consent prior to initial delivery of covered services via telehealth. Finding 4.4.1: The Plan did not ensure that providers obtain either verbal or written consent, including all required consent elements, before providing telehealth services.

Category 5 – Coverage and Authorization of Services

The Plan is required to operate a Utilization Management (UM) program to ensure members access SMHS. The Plan shall decide to grant, modify, or deny initial treatment authorization requests from hospitals or Psychiatric Health Facilities (PHF) and must inform the requester within 72 hours. When medically necessary, hospitals or PHF must submit continued-stay-authorization requests before the end of the current authorization, and the Plan must decide within 24 hours. Finding 5.2.1: The Plan did not ensure that concurrent authorization reviews for psychiatric inpatient hospital services were conducted.

The Plan is required to conduct concurrent review and authorization for administrative day service claims, including documenting the requirements outlined in *Behavioral Health Information Notices (BHIN) 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services*. Finding 5.2.2: The Plan's policy and procedures for authorizing administrative days did not have all the documentation requirements outlined in *BHIN 22-017*.

The Plan is required to utilize referral and/or concurrent review and authorization for Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). Finding 5.2.3: The Plan did not have policies and procedures to ensure that referrals, concurrent review, and authorization are completed for all CRTS and ARTS.

The Plan is required to have a procedure for expedited transfers within 48 hours of placement of the foster child or youth outside the county of original jurisdiction. Finding 5.3.1: The Plan did not include a procedure in its policy for facilitating expedited transfers within 48 hours when a foster child or youth is placed outside the county of original jurisdiction.

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 SMHS 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 – 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: Six member files were reviewed for evidence of referrals from a Managed Care Plan to the Mental Health Plan, initial assessments, and progress notes of treatment planning and follow-up care between the Managed Care Plan and the Mental Health Plan.

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 obtain verbal or written consent for the use of telehealth services.

Category 5 – Coverage and Authorization of Services

Service Authorizations: One member file was reviewed for evidence of appropriate service authorization request.

Treatment Authorizations: Nine member files were reviewed for evidence of appropriate treatment authorization 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 4 – Access and Information Requirements

4.4 Telehealth Beneficiary Consent

4.4.1 Consent of Telehealth Services

The Plan is required to comply with all applicable BHINs issued by DHCS. *(Contract 22-20123 A1, Exhibit E (6)(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* (reviewed 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 07/08/2022), stated that if a visit is provided through telehealth, the health care provider is required to confirm consent for the telehealth service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal member. 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.

A verification study of eight out of nine medical records revealed that no consents were obtained before the rendering of telehealth services:

- Five cases did not include a member consent for telehealth services.
- Three cases included the telehealth consent; however, these consents were obtained after the service was provided.
    - For example, the telehealth consent for two members was dated outside the review period, on October 24, 2024, while the dates of the telehealth services for both members were in July 2023.
    - A third sample received a medical evaluation telehealth service in August 2023, but the only telehealth consent form was dated eight months later, on April 19, 2024.

During the interview, the Plan explained that they did not have telehealth providers until 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.

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 UM program that is responsible for assuring that members have appropriate access to SMHS as required in the *California Code of Regulations, Title 9, section 1810.440(b)(1)-(3)*. The UM program shall evaluate medical necessity, appropriateness, and efficiency of services provided to Medi-Cal members prospectively or retrospectively. *(Contract 22-20123 A1, Exhibit A, Attachment 6 (1)(A)(B))*

The Plan shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. *(Contract 22-20123 A1, Exhibit A, Attachment 6 (2)(A)(1) and Code of Federal Regulations, Title 42, section 438.210 (b)(1))*

The Plan shall decide whether to grant, modify, or deny the hospital or PHF initial treatment authorization request and communicate the decision to the requesting hospital or PHF not later than 72hours after receipt of the request for services.

When medically necessary for the member, before the end of the initial authorization period, or a subsequent authorization period, the hospital or PHF shall submit a continued-stay-authorization request for a specified number of days to the Plan. The Plan shall issue a decision on a hospital or PHF's continued-stay-authorization request within 24 hours of receipt of a request. The Plan is required to establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services. The Plan is required to have mechanisms in effect to ensure consistent application of review criteria for authorization decisions. *(BHIN 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services)*

Plan policy, *200.6 Oversight of Clients' Inpatient Treatment* (reviewed 07/17/2013), stated the in-hospital review team will evaluate medical necessity of placement, appropriateness, effectiveness, and efficiency of services provided.

Finding: The Plan did not have a concurrent review process to ensure authorization of psychiatric inpatient hospital services.

A verification study of nine members who received inpatient psychiatric services, with stays ranging from 5 to 13 days, revealed that none had medical records confirming authorization decisions from the Plan within 72 hours of hospital admission, nor did they have concurrent authorization for continued-stay within 24 hours of the hospital's request.

During the interview, the Plan stated that they were unaware of the concurrent review requirement and confirmed that the sampled members' hospital services were reviewed retrospectively. The Plan explained that due to its low hospitalization rate, coordination with hospitals is generally conducted verbally with the nurses. However, this process does not follow the required concurrent inpatient review process, per *BHIN 22-017*.

Plan policy *200.6* does not contain any concurrent review procedures in accordance with *BHIN 22-017*. Additionally, Plan policy *200.6* was last reviewed in 2013 and has not been updated to include timeframe requirements.

When the Plan does not have a process in place to conduct concurrent reviews, it cannot evaluate the medical necessity and appropriateness of in-hospital stays.

Recommendation: Develop and implement policies and procedures to ensure concurrent authorization of psychiatric inpatient hospital services.

5.2.2 Authorizing Administrative Days

The Plan is required to comply with all applicable BHINs issued by DHCS. *(Contract 22-20123 A1, Exhibit E (6)(B))*

In order to conduct concurrent review and authorization for administrative day service claims, the Plan shall review that the hospital has documented the following:

1. 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.
2. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the member is placed on administrative day status can be authorized.
3. 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.

4. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without contact having been made and documented.
5. The Plan may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the member. The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact.

The Plan is required to maintain policies and procedures for demonstrating ongoing compliance with the *BHIN*. *(BHIN 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services)*

Plan policy, *200.2 Authorization for Specialty Mental Health Services* (revised 09/08/2020), stated in order to conduct concurrent review and authorization for administrative day services, the Plan shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (excepting weekends and holidays). Once five contacts have been made and documented, any remaining days within a seven-consecutive-day period from the day the member is placed on administrative status may be authorized. The Plan may waive the five contacts per week requirement if there are fewer than five appropriate non-acute residential treatment facilities available as placement options. The lack of available treatment facilities shall be documented and include the status of placement, date of contact, and signature of the person making contact.

Finding: The Plan's policy and procedures for authorizing administrative days did not have all the documentation requirements outlined in *BHIN 22-017*.

Plan policy *200.2* does not have two of the five documentation requirements for authorizing administrative days as follows:

1. 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.
2. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without contact having been made and documented.

In a written response, the Plan acknowledged that its current policies do not address all the components required by *BHIN 22-017* and will remedy the deficiency through the corrective action process.

When the Plan's policy does not include all the documentation requirements specified in *BHIN 22-017*, the authorization of administrative days may be delayed, which can compromise the continuity and quality of care for members.

Recommendation: Revise and implement policy and procedures to incorporate the documentation requirements for authorizing administrative days as outlined in *BHIN 22-017*.

5.2.3 Crisis Residential Treatment Services and Adult Residential Treatment Services

The Plan is required to comply with all applicable BHINs issued by DHCS. *(Contract 22-20123 A1, Exhibit E (6)(B))*

The Plan must utilize referral and/or concurrent review and authorization for CRTS and ARTS. The Plan may not require prior authorization. If the Plan refers a member to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the Plan specifies the parameters (e.g., number of days authorized) of the authorization. The Plan must then re-authorize medically necessary CRTS and ARTS, as appropriate, concurrently with the member's stay and based on the member's continued need for services. The Plan shall establish and implement written policies and procedures to address the authorization of SMHS in accordance with this BHIN. *(BHIN 22-016, Authorization of Outpatient Specialty Mental Health Services)*

Plan policy, *200.6 Oversight of Client's Inpatient Treatment* (reviewed 07/17/2013), stated the procedure for inpatient concurrent review, inpatient level of care, documentation required for determining the appropriateness of inpatient stay, inpatient concurrent review function, and timeframes for concurrent review requests.

Finding: The Plan did not have policies and procedures to ensure that referrals, concurrent review, and authorization are completed for all CRTS and ARTS.

During the interview, the Plan explained that because it has a small population receiving CRTS and ARTS, it meets with the person responsible at the facility weekly and conduct quarterly in-person visits with the directors and staff to provide updates about the member. However, the updates on the members' status are not documented, and this

procedure is not outlined in the Plan's policy. The Plan confirmed that it does not have policies or procedures to address the referral, concurrent review, and authorization processes for CRTS and ARTS.

When the Plan does not establish policies and procedures for referral, concurrent review, and authorization processes for CRTS and ARTS, members may experience interruptions in receiving medically necessary services, which can negatively impact their care and recovery.

Recommendation: Develop and implement policies and procedures to ensure that referrals, concurrent reviews, and authorizations are completed for CRTS and ARTS.

5.3 Presumptive Transfer

5.3.1 Expedited Presumptive Transfers

The Plan is required to follow *Mental Health and Substance Use Disorder Services Information Notice 18-027, Presumptive Transfer Policy* Guidance, issued by DHCS. *(Contract 22-20123 A1, Exhibit A, Attachment 7 (4)(B))*

The Plan is required to have a procedure for expedited transfers within 48 hours of placement of the foster child or youth outside of the county of original jurisdiction. *(Mental Health and Substance Use Disorder Services Information Notice 18-027, Presumptive Transfer Policy Guidance and California Welfare and Institutions Code section 14717.1, subdivision (b)(2)(F)(g))*

Plan policy, *100.19 Presumptive Transfer* (approved 08/23/2023), stated that in situations when a foster child or youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition, the Plan will provide SMHS immediately, and without prior authorization. *California Welfare and Institutions Code section 14717.1, subdivision (b)(2)(F)* requires a procedure for expedited transfers within 48 hours of placement of the foster child or youth outside of the county of original jurisdiction. There may be instances when a child or youth must be moved to a new placement outside of the county of original jurisdiction for his or her safety, and a Child and Family Team meeting is unable to be convened prior to placement. In these instances, the county placing agency must immediately contact the county of residence to notify the Plan of the placement and the need to provide or arrange and pay for SMHS to meet the needs of the child or youth.

Finding: The Plan did not include a procedure in its policy for facilitating expedited transfers within 48 hours when a foster child or youth is placed outside the county of original jurisdiction.

The Plan's policy *100.19* does reference expedited transfers and mentions the 48-hour requirement. However, the reference is only a citation of the legal requirement, not a procedure that operationalizes how the Plan will ensure or implement that 48-hour expedited transfer.

As a CAP to the prior fiscal year 2021/2022 audit Finding 5.3.8, the Plan developed a comprehensive policy and procedure describing its process for the timely provision of services to children and youth, including foster youth. The CAP also stated that the Plan will have a procedure for expedited transfers within 48 hours of placement of the foster child or youth outside of the county of original jurisdiction. However, the policy does not outline the specific procedures the Plan will follow to implement the 48-hour expedited transfer.

During the interview, the Plan explained that procedures for 48-hour expedited transfers are outlined in Plan policy, *100.7 Timely Access to Services* (revised 08/05/2024). However, the policy was revised outside of the audit period and still does not address the procedures for a 48-hour expedited transfer. Instead, it focuses on requirements related to the conditions for approving a waiver under presumptive transfer. The Plan also submitted a Request for Services form as additional evidence. This form includes a question about whether the request pertains to a child in foster care. If the answer is yes, the request is considered urgent. However, the additional evidence did not provide procedures for a 48-hour expedited transfer.

When the Plan does not have a procedure for expedited transfers within 48 hours for foster children or youth placed outside the county of original jurisdiction, it may lead to poor communication between counties, providers, and caregivers, resulting in delays in care coordination and effective service delivery.

This is a repeat finding of the 2021-2022 Review - Coverage and Authorization of Services.

Recommendation: Revise and implement policies and procedures, including a procedure for facilitating expedited transfers within 48 hours when a foster child or youth is placed outside the county of original jurisdiction.