DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

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

Contract Number: 22-20107

Contract Type: Specialty Mental Health Services

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

Dates of Audit: December 2, 2025 — December 12, 2025

Report Issued: May 29, 2026

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I. INTRODUCTION

Kings 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.

Kings County is located in the Central Valley, also known as San Joaquin Valley of California. The Plan provides services within the unincorporated county and in four cities: Avenal, Corcoran, Hanford, and Lemoore.

As of September 23, 2025, the Plan had a total of 3,357 members receiving services.

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 December 2, 2025, through December 12, 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 May 13, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On May 22, 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, Member 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 not completely closed at the time of the audit.

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 member care services with Managed Care Plans (MCPs) and ensure medically necessary services were made available to members. Finding 2.1.1: The Plan did not coordinate member care services with MCPs to ensure medically necessary services were made available to members.

Category 4 – Access and Information Requirements

The Plan is required to provide all written materials for members in alternative formats, including braille. Finding 4.1.1: The Plan did not ensure that alternative formats, including braille, were available to its members.

Category 5 – Coverage and Authorization of Services

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

Category 6 – Member 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 December 2, 2025, through December 12, 2025, for the audit period of July 1, 2024, through June 30, 2025. 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

Mobile Crisis Services: Ten member files were reviewed for evidence of response and follow-up, assessment, documentation, and provision of services in appropriate settings.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Ten member files were reviewed for evidence of referrals from the Mental Health Plan (MHP) to a Managed Care Plan (MCP), initial assessments, and progress notes of treatment planning and follow-up care between the MHP and the MCP.

Category 4 – Access and Information Requirements

Access Line Test Calls: Seven test calls were made to the Plan's statewide 24/7 toll-free number to confirm compliance with regulatory requirements regarding requesting information about how to access SMHS and services to treat urgent conditions and how to use the member problem resolution and fair hearing processes.

Access Test Call Log: Five required test calls were made and review of Plan's call log to ensure logging of each test call and confirm the log contained all required components.

Member Telehealth Consent: Ten telehealth consent samples were reviewed for evidence of documentation of telehealth consent prior to the initial delivery of telehealth services.

Category 5 – Coverage and Authorization of Services

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

Category 6 – Member Rights and Protection

Grievance Procedures: Five Quality of Care and five Quality of Service grievances were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for review.

Appeal Procedures: One appeal 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 2 – Care Coordination and Continuity of Care

2.1 Coordination of Care Requirements

2.1.1 Care Coordination with Managed Care Plans

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

The Plan shall coordinate the services the Plan furnishes to the member with the services the member receives from any other managed care organization, in Fee-for-service Medi-Cal, from community and social support providers, and other human services agencies used by its members. *(Contract, Exhibit A, Attachment 10, section 1(A)(2); Code of Federal Regulations (CFR), Title 42, section 438.208(b)(2)(i)-(iv); California Code of Regulations (CCR), Title 9, section 1810.415)*

Plans 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 *A-105, Adult and Youth MHP Transition of Care Tool (effective January 1, 2023)* stated that after the Transition of Care Tool is completed, the member shall be referred to their MCP, or directly to an MCP provider delivering non-specialty mental health services if appropriate processes have been established in coordination with MCPs. Plans 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.

Plan's *Memorandum of Understanding (MOU) with Blue Cross of California Partnership Plan, Inc., Kaiser Foundation Health Plan, Inc., CalViva Health, Health Net Community Solutions, Inc., and Kings County Behavioral Health (effective August 27,2024)* stated the

MCP, and the Plan must use the required Transition of Care Tool to facilitate transitions of care for members when their service needs change. Provides referrals to MCP, and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the member has been connected with a network provider who accepts their care and that services have been made available to the member.

Finding: The Plan did not coordinate member care services with MCPs to ensure medically necessary services were made available to members.

In a verification study, seven of ten samples revealed that the Plan referred members to the MCP using the Transition of Care tool. However, the Plan did not provide documentation that it ensures the referral process has been completed, the member has been connected with a provider, the new provider accepted the care, and medically necessary services have been made available.

In an interview, the Plan shared several factors contributing to the absence of its communication with MCPs during the audit period. The Plan understood it must follow through with a referral. Furthermore, the Plan acknowledged the need to enhance care coordination training to improve document-sharing with its MCPs moving forward. The Plan did not provide additional evidence.

When the Plan does not follow up on member referrals to MCPs, it can result in delays in members receiving a timely assessment and services performed by an MCP mental health provider.

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.

COMPLIANCE AUDIT FINDINGS

Category 4 – Access and Information Requirements

4.1 Language and Format Requirements

4.1.1 Braille Alternative Format

The Plan is required to provide all written materials for members in easily understood language, format, and alternative formats that take into consideration the special needs of members. *(Contract, Exhibit A, Attachment 11 (1)(A))*

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

Medi-Cal Behavioral Health delivery systems (Mental Health Plans, Drug Medi-Cal-Organized Delivery System counties, and Drug Medi-Cal counties), and their subcontractors must provide a member who is blind or visually impaired, and other individuals with disabilities, with communication materials in the individuals requested standard and non-standard alternative format(s).

The standard alternative formats options are large print, audio CD, data CD, and Braille.

- Large print: At least 20pt font or larger
- Audio CD: Provides the ability to hear notices and information. Files in the CD are not encrypted.
- Data CD: This allows for the use of computer software to read notices and other written information. Files in the CD are not encrypted.
- Braille: Uses raised dots that can be read with fingers.

(BHIN 24-007; Effective Communication, Including Alternative Formats, for Individuals with Disabilities)

Plan policy *A-084, Mental Health Informing Materials (effective May 16, 2023)* described requirements for providing informing materials in alternate formats upon request. The policy specifies that members who are visually impaired may receive informing materials in large print (font size 14pt or larger) or loaded onto a CD or thumb drive for use with audio reader software.

Finding: The Plan did not ensure that alternative format, braille, was available to its members.

Plan policy A-084 addressed provisions of informing materials in alternative formats upon request. However, the policy did not include the provision of informing materials in braille.

In an interview, the Plan acknowledged that written procedures for procuring braille were not available during the audit period. The Plan described its process for fulfilling braille requests as verbal. The Plan also did not identify any trainings disseminated to staff or providers during the audit period that addressed alternative format requirements and the training evidence requested was not provided.

When the Plan does not ensure that alternative format, braille, is available to members, it may not ensure consistent and accessible communication for members with disabilities. This limits members' access and prevents them from having adequate knowledge to make informed decisions. This may 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 alternative format, braille, is available to its members.