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

DHCS Audits and Investigations
Contract and Enrollment Review Division
Central Branch

Contract Number: 22-20132
Contract Type: Specialty Mental Health Services
Audit Period: July 1, 2024 — June 30, 2025
Dates of Audit: April 28, 2026 — May 8, 2026
Report Issued: September 4, 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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I. INTRODUCTION

San Mateo County BHRS (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.

San Mateo County BHRS is located Northern California. The Plan provides SMHS services within 16 unincorporated cities: Broadmoor, Burlingame Hills, Devonshire, Emerald Lake Hills, Fair Oaks, Highlands/Baywood Park, Ladera, Los Trancos Woods/ Vista Verde, Menlo Oaks, North Fair Oaks, Palomar Park, Princeton, South Coast/Skyline, Sequoia Tract/Skylond, Stanford Lands, and West Menlo Park.

As of June 30, 2025, the Plan had a total of 9,893 members receiving services and a total of 1,072 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 April 28, 2026, through May 8, 2026. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on August 18, 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 September 1, 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 five categories of performance: Care Coordination and Continuity of Care, Quality Assurance and Performance Improvement, Access and Information Requirements, Member Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2021, through June 30, 2022, 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 follows:

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 member consent including criteria outlined in Behavioral Health Information (BHIN) 23-018 prior to initial delivery of covered services via

telehealth. Finding 4.4.1: The Plan did not ensure all providers obtained, explained, and documented all required elements listed in BHIN 23-018 when collecting verbal and written telehealth consents prior to the delivery of telehealth services.

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 April 28, 2026, through May 8, 2026, 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 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 2 – Care Coordination and Continuity of Care

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

Category 3 – Quality Assurance and Performance Improvement

There were no verification studies conducted for the audit review.

Category 4 – Access and Information Requirements

Access Line Test Calls: Seven test calls requesting information about SMHS and how to treat an urgent condition were made to the Plan's statewide 24/7 toll free number to confirm compliance with regulatory requirements and 15 member records were reviewed for evidence of telehealth consent and required elements were met prior to initial delivery of telehealth services.

Category 6 – Member Rights and Protection

Grievance and Appeal Procedures: 14 grievances of quality of care and one appeal were reviewed for a timely resolution, appropriate response to the complaint and submission to the appropriate level for review.

Category 7 – Program Integrity

There were no verification studies conducted for the audit review.

COMPLIANCE AUDIT FINDING

Category 4 – Access and Information Requirements

4.4 Telehealth Requirements

4.4.1 Telehealth Consent Services

The Plan is required to comply with all applicable federal and state law, statutes and regulations, the terms of the contract, with Behavioral Health Information Notices (BHIN), and any other applicable authorities. *(Contract, Exhibit E, Additional Provisions (6)(B))*

The Plan is responsible for obtaining member consent prior to initial delivery of services covered 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.

Providers must also document the member's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. *(BHIN 23-018) Updated Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal (April 25, 2023)*

Plan policy *22-04, Documentation Requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services (revised June 9, 2022)* If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in- person, face-to-face visit; an explanation that use of telehealth

is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi- Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider. The provider must document in the medical record the provision of this information and the client's verbal or written acknowledgment that the information was received.

Finding: The Plan did not ensure that all providers obtained, explained, and documented all required elements listed in BHIN 23-018 when collecting verbal and written telehealth consents prior to the initial delivery of telehealth services.

Although the Plan's policy *22-04* aligns with the telehealth consent requirements, the verification study revealed that nine of 15 telehealth services did not meet all the telehealth consent requirements:

- Four written samples did not include two elements; the right to access covered in person and the availability of non-medical transportation benefits.
- Three samples did not have written or verbal consent documented.
- Two samples no consents were obtained prior to the initial delivery of the telehealth services.

A review of the Plan's 2020 telehealth consent form did not include the following: (1) The member has a right to access covered services in person (2) Non-medical transportation benefits are available for in-person visits. The Plan's continuous usage of the 2020 telehealth consent form is attributed to members not receiving all the explanations of the required BHIN 23-018 elements.

In an interview, the Plan acknowledged due to other operational priorities caused delays of telehealth consent forms updates and overlooking the BHIN 23-018 requirements. The Plan stated that they offered clinical consent training; however, it did not cover the necessary required elements of BHIN 23-018. In addition, the Plan's annual chart audit tool only monitors if the consent form is present in the medical chart for the date of service, but it did not monitor that all required elements of telehealth consent are explained to the member.

When the Plan does not ensure that its providers are appropriately obtaining, explaining, and documenting verbal and written telehealth consent required elements;

this may lead members to making uninformed health decisions due to the lack of insufficient knowledge about treatment.

Recommendation: Implement policies and procedures to ensure all providers obtain, explain, and document verbal and written telehealth consent with all the required elements of the BHIN 23-018 prior to the initial delivery of telehealth services.