

DHCS AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SANTA ANA SECTION

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

Contract Number: 22-20092

Contract Type: Specialty Mental Health Services

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

Dates of Audit: October 21, 2025 — October 31, 2025

Report Issued: May 13, 2026

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I. INTRODUCTION

Alameda County Behavioral Health Services (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.

Alameda County is located in Northern California. The Plan provides services within the unincorporated county and in 20 cities: Alameda, Albany, Berkeley, Emeryville, Oakland, Piedmont, Hayward, San Leandro, Castro Valley, Asland, Cherryland, San Lorenzo, Fairview, Fremont, Union City, Newark, Livermore, Dublin, Pleasanton, Sunol.

As of June 2025, the Plan had a total of 21,192 members receiving Specialty Mental Health services and a total of 436 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 October 21, 2025, through October 31, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

In accordance with the California Code of Regulations, Title 22, section 51021, an Exit Conference with the Plan was offered on April 29, 2026. The Plan declined to hold an Exit Conference, as there were no areas of noncompliance found in this review. This report reflects the evaluation of all relevant information received during the audit. There were no findings in this review.

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, 2022, through June 30, 2023, identified deficiencies incorporated in the Corrective Action Plan (CAP), which were later closed. This year's audit included a review of the Plan's compliance with its DHCS Contract and assessed its implementation of the prior year's CAP.

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 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 Contract.

PROCEDURE

DHCS conducted an audit of the Plan from October 21, 2025, through October 31, 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: Eight medical records were reviewed for appropriate services, which include coordination of care, crisis assessment, follow-up treatment, safety plans and evidence of warm hand off.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: 12 member referrals from the Managed Care Plan (MCP) to the Mental Health Plan (MHP) and twelve member referrals from the MHP to MCP were reviewed for evidence of referrals, initial assessments, progress notes of treatment planning and follow-up care between the MCP and the MHP.

Category 4 – Access and Information Requirements

Access Line Test Calls: Two test calls requesting information about specialty mental health services (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; two test calls requesting information about the beneficiary problem resolution and fair hearing processes were made to the Plan's statewide 24/7 toll-free number to confirm compliance with regulatory requirements.

Access Line Test Call Log: The Plan's call log was reviewed to ensure all required log components were documented for four test calls made to the Plan.

Telehealth Services: 12-medical records were reviewed to confirm compliant member consent for telehealth services.

Category 5 – Coverage and Authorization of Services

Treatment Authorization (TA): 12 medical records were reviewed for evidence of appropriate treatment authorization, including the concurrent review authorization process.

Crisis Residential Treatment (CRT): 12 medical records were reviewed for evidence of appropriate service authorization, including the SAR concurrent review process.

Adult Residential Treatment (ART): Eight medical records were reviewed for evidence of appropriate service authorization, including the SAR concurrent review process.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: 12 grievances were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for service and care.

Appeals Procedures: Three appeals 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.