

DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
CENTRAL BRANCH

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

Contract Number: 22-20120

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2024 — December 31, 2024

Dates of Audit: February 3, 2026 — February 13, 2026

Report Issued: May 21, 2026

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I. INTRODUCTION

Nevada 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.

Nevada County Behavioral Health is in Grass Valley, California which is part of the Sierra Nevada foothills and mountain range. The Plan provides services within three incorporated cities, Grass Valley, Nevada City, and Truckee. Notably, 67% of residents live in unincorporated areas such as Alta Sierra, Lake of the Pines, Penn Valley, North San Juan, Rough and Ready, and Cedar Ridge.

As of December 31, 2024, the Plan had a total of 1,728 members receiving services and a total of eleven active providers.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services audit for the period of July 1, 2024, through December 31, 2024. The audit was conducted from February 3, 2026, through February 13, 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 May 6, 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 12, 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 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, 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 onsite.

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 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 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 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 Contract.

PROCEDURE

DHCS conducted an audit of the Plan from February 3, 2026, through February 13, 2026, for the audit period of July 1, 2024, through December 31, 2024. 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 Plan representatives.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

Mobile Crisis Service Encounters: 10 verification studies were conducted for the audit review.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: 10 member files were reviewed for evidence of referrals from a Managed Care Plan (MCP) to Mental Health Plan (MHP), and 10 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

Member Telehealth Consent: 15 member files were reviewed for evidence of telehealth consent and required elements.

Category 5 – Coverage and Authorization of Services

Service Authorizations: Nine concurrent reviews of ARTS, one CRTS, and 15 hospital and PHF were conducted for the audit review.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: Nine grievances of quality of care and three quality of service, 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 FINDINGS

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, 214, *Telehealth Provisions (revised 12/23/2024)* states providers are required prior to initial delivery of covered services via telehealth, 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.

The policy further states that providers must also document the members' verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services.

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 214 aligns with the telehealth consent requirements, the verification study revealed that seven of 15 telehealth services reviewed did not meet all the telehealth consent requirements:

- Four of 15 samples, the Plan did not obtain written or verbal consents, prior to the initial delivery of the telehealth services.
- Three of 15 samples lacked documentation, two written consents, did not include the right to access covered services in person, and the availability of non-medical transportation benefits. One verbal consent was incomplete and only the covered risks and limitations were documented.

In an interview, the Plan acknowledged that they did not communicate or provide training to its providers on BHIN 23-018 requirements. The Plan also stated the chart monitoring process was suspended during the audit period. In addition, the audit team reviewed the chart audit monitoring tool, which was the Plan's primary control to verify that telehealth consent was documented in the member's chart. However, the Plan's chart audit tool is limited in scope; it does not specifically 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.