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

DHCS Audits and Investigations
Contract and Enrollment Review Division
Central Branch

Contract Number: 22-20139
Contract Type: Specialty Mental Health Services
Audit Period: July 1, 2024 — June 30, 2025
Dates of Audit: June 22, 2026 — June 26, 2026
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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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I. INTRODUCTION

County of Sonoma 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.

County of Sonoma is located in Northern California. The Plan provides services within eight cities and one unincorporated city of Guerneville, CA.

As of June 30, 2025, the Plan had a total of 4,791 members receiving services and a total of 64 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 June 22, 2026, through June 26, 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 September 10, 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 23, 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, 2020, through June 30, 2023, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was 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 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

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 obtain consent and explain nor document all required consent information prior to the initial 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 – Member Rights and Protection

The Plan shall maintain a grievance log and log the grievances within one working day of the date of receipt of the grievance. Finding 6.1.2: The Plan did not ensure grievances were logged within one working day of the date of receipt.

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 June 22, 2026, through June 26, 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 1 – Network Adequacy and Availability of Services

Mobile Crisis Service: Ten members' service encounters were reviewed for evidence of initial face-to-face crisis assessment, screening, treatment and follow-up care.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Ten member records 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 4 – Access and Information Requirements

Telehealth Consent: 15 member records were reviewed for evidence of telehealth consent and that all required elements were met prior to initial delivery of telehealth services.

Category 5 – Coverage and Authorization of Services

Service Authorizations: Ten inpatient psychiatric member records were reviewed for evidence of appropriate treatment authorizations and for consistent application of criteria for authorization decisions.

Category 6 – Member Rights and Protection

Grievance and Appeal Procedures: 15 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 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 *7.1.8 Telehealth Services (revised 6/27/2024)* states, prior to initial delivery of services, the provider must: (1) Obtain verbal or written consent for the use of telehealth; (2) Explain (a) The beneficiary has a right to access covered services in person (b) 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. (c) Non-medical transportation benefits are available for in-person visits (d) 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 the provider must document the member's verbal or written consent via the Consent for Telehealth form in SmartCare.

Finding: The Plan did not obtain consent and explain nor document all required consent information prior to the initial delivery of telehealth services.

Although the Plan's policy *7.1.8* aligns with the telehealth consent requirements, the verification study revealed that three of 15 samples did not comply with all telehealth requirements:

- One member record did not have telehealth consent prior to the initial telehealth encounter.
- Two member records contained the right telehealth forms, but these forms lacked a signature or documentation of verbal consent.

In an interview, the plan acknowledged they did not review telehealth consents for the elements of BHIN 23-018, and do not have a process to ensure member consents are updated after the release of BHIN 23-018 and lack an internal process to capture and address any workflow gaps and issues arising from users when collecting verbal and written telehealth consents prior to the initial delivery of telehealth services.

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 explain, obtain, and document member consent prior to the initial delivery of telehealth services.

COMPLIANCE AUDIT FINDINGS

Category 6 – Member Rights and Protection

6.1 Member Problem Resolution

6.1.2 Handling of Grievances

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 shall maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. *(42 C.F.R. § 438.416(a); Cal. Code Regs., tit. 9, § 1850.205(d)(1). (Contract, Exhibit A, Attachment 12, 2, A)*

The Plan shall maintain a grievance and appeal log and written record for each grievance, appeal, and expedited appeals received by the Plan. The Plan shall log within one working day of the date of receipt of the grievance or appeal. (*Mental Health Plan and Drug Medi-Cal Organized Delivery System Plan Grievance and Appeal Requirements with Revised Member Notice Templates BHIN 25-014 (April 24, 2025*))

Plan Policy *7.1.2 Member Grievances and Discrimination Grievances, (Revised 1/21/2025)* Grievances and Discrimination Grievances shall be filed verbally or in writing, to the Grievance Coordinator and shall be resolved expeditiously as the member's health condition requires, not to exceed 30 calendar days from the day the Plan receives the grievance. The Plan shall maintain a grievance log and record grievance receipt dates in the log within one business day of the date of receiving the grievance.

Plan's *Grievance Coordinator Workflow (FY 2025-26)* states, when a Change of Provider (COP) request is received, the Quality Assessment and Performance Improvement Team will forward all COPs to be reviewed for potential grievance. The day of receipt, the COP should be evaluated to determine if the request indicates a level of dissatisfaction aligned with the designated grievance types (Quality of Care, Discrimination, Medication Concerns, etc.) if identified as grievance, contact filer to inquire and initiate the grievance. In the event filer does not wish to disclose their identity or if grievance is filed

via COP and the client does not wish to pursue/engage in the grievance process. Input anonymous in the field to capture the name of the person filing the grievance.

Finding: The Plan did not ensure grievances were logged within one working day of the date of receipt.

A verification study revealed that four of 15 Quality of Care (QOC) grievances were not logged within one working date of receipt of the grievance. While the Plan's policy requires to log all grievances within one working day of receipt, the four grievances showed that they were logged 3 to 20 days after the member notified the Plan of dissatisfaction and filed a COP request.

Although the Plan's Policy *7.1.2* meets the contractual timeframe requirement for logging of grievances, the Plan's Grievance Workflow did not specify the requirement to log the grievances within one working day of the date of receipt.

In an interview, the Plan acknowledged it delay logging the grievances within one working day of receipt because they waited for the evaluation and completion of the COP to determine if the request indicated a level of dissatisfaction. In addition, the Plan does not have a process to ensure that all grievances are logged within one working day from the date of receipt of the grievance.

When grievances are not logged within one working day, members may experience delays in receiving care and can lead to poor health outcomes.

Recommendation: Revise and implement a process to ensure grievances are logged within one working day from the date of receipt.