DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

LOS ANGELES SECTION

REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF RIVERSIDE COUNTY MENTAL HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 22-20124

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2023 — June 30, 2024

Dates of Audit: May 13, 2025 — May 23, 2025

Report Issued: October 10, 2025

TABLE OF CONTENTS

I. INTRODUCTION

Riverside 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.

Riverside County is located in Southern California. The Plan provides services within the unincorporated County and in 13 cities: Riverside, Moreno Valley, Corona, Perris, Sun City, Menifee, Wildomar, Temecula, Hemet, Palm Springs, Palm Desert, Indio, and Blythe.

As of June 2025, the Plan had a total of 31,362 members receiving services and a total of 1,476 active providers.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS audit for the period of July 1, 2023, through June 30, 2024. The audit was conducted from May 13, 2025, through May 23, 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 September 23, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On October 8, 2025, 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, Beneficiary 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. The prior year's Corrective Action Plan was closed at the time of the onsite visit. This audit included a review of documents to determine the implementation and effectiveness of the Plan's corrective actions.

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

Finding 4.4.1: The Plan is required to explain to members their telehealth rights included in the *Behavioral Health Information Notice (BHIN) 23-018, Updated Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal, (04/25/2023)*. The Plan did not explain to members that their telehealth rights included access to covered services in person and that Non-Medical Transportation benefits are available for in-person visits.

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

Finding 6.2.1: For standard grievances, the Plan must provide members with a written acknowledgement of the grievance's receipt and a resolution letter. The Plan did not send the written acknowledgement of the grievance and the Notice of Grievance Resolution (NGR) letter to the members.

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 May 13, 2025, through May 23, 2025, for the audit period of July 1, 2023, through June 30, 2024. The audit included a review of the Plan's policies for providing services, procedures to implement the policies, and the process to determine whether the 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 Benefit: Twelve medical records were reviewed for the provision of services.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Thirty-two bi-directional referrals from the managed care plan to the mental health plan were reviewed for evidence of referrals, initial assessments, progress notes of treatment planning, and follow-up care between the managed care plan and the mental health plan.

Category 4 – Access and Information Requirements

Telehealth: Ten member files were reviewed for evidence of informed consent, completeness, and timeliness.

Category 5 – Coverage and Authorization of Services

Service Authorizations: Ten crisis residential treatment services member files were reviewed for evidence of appropriate service authorization requests.

Treatment Authorizations: Five inpatient treatment facility files, five psychiatric health facility files, and five fee-for-service files were reviewed for evidence of appropriate treatment authorization including the concurrent review authorization process.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: Ten 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 was 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 Requirements

The Plan has an affirmative responsibility to obtain member consent prior to initial delivery of covered services 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 member: 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. (*BHIN 23-018, Updated Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal, (04/25/2023))*

Plan policy, *262 Telemedicine & Telehealth Use* (effective 03/09/2015), attachment B telehealth consent form includes two of the four *BHIN 23-018* requirements.

- The 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.
- Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.

Finding: The Plan's telehealth consent form did not include two required elements: members' rights to access covered services in person, and Non-Medical Transportation benefits are available for in-person visits.

The Plan's policy did not disclose *BHIN 23-018's* four required elements. The policy only noted that the member must sign the telehealth informed consent before services are provided.

In a verification study, seven of ten samples showed missing and improperly documented telehealth consents.

One consent was missing for a telehealth service rendered to a member.

Six consents were obtained prior to the provision of telehealth services but were not documented to indicate that all consent information components were explained to and agreed upon by the member. The review of the telehealth consent form template did not contain two of the four required elements. The missing elements of the consent form were information on members' rights to access covered services in person and that Non-Medical Transportation benefits are available for in-person visits.

In an interview, the Plan acknowledged that the telehealth consent form did not include all the requirements listed in *BHIN 23-018*. The policy and procedure provided were not updated during the review period.

When the Plan does not explain all telehealth-covered services, members will not receive all the information necessary to make informed decisions about their care.

Recommendation: Revise and implement the policy and procedure to ensure the Plan's telehealth consent form includes access to covered services in person and that Non-Medical Transportation benefits are available for in-person visits.

COMPLIANCE AUDIT FINDINGS

Category 6 – Beneficiary Rights and Protection

6.2 Handling Grievances and Appeals

6.2.1 Written Grievance Letters

The contractor shall provide the member with a written acknowledgement of receipt of the grievance. The written acknowledgement to the member must be postmarked within five calendar days of receipt of the grievance. *(Contract, Exhibit A, Attachment 12, 3(B))*

Grievances received over the telephone or in person by the contractor, or a network provider of the contractor, that are resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written notification of resolution using the written NGR form. *(Contract, Exhibit A, Attachment 12, 3(B))*

Each Plan must resolve grievances within the established timeframes. For standard resolution of a grievance and notice to affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the Plan receives the grievance. *(BHIN 18-010E, Federal Grievance and Appeal System Requirements with Revised Beneficiary Notice Templates, (03/27/2018))*

The Plan shall use the enclosed written NGR to notify the member of the results of the grievance resolution. (*BHIN 18-010E, Federal Grievance and Appeal System Requirements with Revised Beneficiary Notice Templates, (03/27/2018))*

Plan policy, *295 Beneficiary / Consumer Issue Resolution Process* (effective 10/10/2001), states that a letter acknowledging the receipt of the grievance will be sent by the Quality Improvement Department to the member/consumer within five calendar days. The member, and/or their representative, will be sent a written decision on the grievance within 90 calendar days of receipt of the grievance by the Quality Improvement Department.

Plan workflow, *Consumer Grievance/Appeals Workflow* (revised 2024), states that if a grievance is received over the phone or in person, and can be resolved to the members' satisfaction by the close of the next business day following receipt, no

acknowledgment or resolution letter needs to be sent. In the Grievance Log, under the Letter/Resolution tab, select "Exempt". All Grievances considered "Exempt" must be discussed with the Quality Improvement Supervisor before finalizing the resolution.

Finding: The Plan did not send the written acknowledgement of the grievance and the NGR to a member.

In a verification study, one of ten grievances showed that the Plan did not adhere to the Contract requirements. The grievance was logged as exempt but was not resolved by the close of the next business day. Grievances not resolved by the close of the next business day are standard grievances. The Plan is required to send the member a written acknowledgement and NGR for standard grievances. The Plan closed the case on day 15 without sending the member a written acknowledgment and the NGR.

In a narrative, the Plan stated that when a grievance is initially received, Plan staff sometimes assume the issue(s) will be resolved the same day and mark it in the database as an exempt grievance. When a grievance was not resolved by the next business day, Plan staff were unable to manually modify the exempt grievance to a standard grievance in the database. The Plan is currently working to resolve this database issue.

Review of training documents showed no specific training regarding grievance classification. The Plan stated that staff receive initial training upon onboarding. However, the Plan acknowledged the need to retrain staff to make grievance case determinations and classification for proper processing and resolution.

When the Plan does not notify members of the acknowledgement and resolution of grievances in a timely manner, members may not have all the information they need to make health care decisions.

Recommendation: Revise and implement policies and procedures to ensure that members receive a written acknowledgement of the grievance and the NGR.