DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

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

Contract Number: 22-20137

Contract Type: Specialty Mental Health Services

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

Dates of Audit: June 3, 2025 — June 20, 2025

Report Issued: October 9, 2025

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I. INTRODUCTION

Siskiyou 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.

Siskiyou County is located in the northern part of the state. The Plan provides services within the unincorporated county and in six cities: Yreka, Mt. Shasta, Weed, Dunsmuir, McCloud, and Tulelake.

As of June 2025, the Plan had a total of 925 members receiving services and a total of 59 active providers.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2023, through June 30, 2024. The audit was conducted from June 3, 2025, through June 20, 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 30, 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 2, 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 five categories of performance: Network Adequacy and Availability of Services, Care Coordination and Continuity of Care, Access and Information Requirements, Coverage and Authorization of Services, 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 audit. Therefore, 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

The Plan is required to coordinate care and complete MCP (Managed Care Plan) referrals by ensuring timely clinical assessments and medically necessary services are made available to members. Finding 2.3.1: The Plan did not coordinate care and complete MCP referrals by ensuring timely clinical assessments and medically necessary services were made available to members.

Category 4 – Access and Information Requirements

The Plan is required to ensure all providers explain and document all required elements listed in BHIN 23-018 when collecting verbal telehealth consents prior to the delivery of

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

Category 5 – Coverage and Authorization of Services

The Plan is required to implement a UM (Utilization Management) Program that performs concurrent review to evaluate the medical necessity and efficiency of services for its members. The Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the Department, notwithstanding any relationship(s) that the Plan may have with any subcontractor. Finding 5.2.1: The Plan did not implement a UM Program to ensure its subcontractor performed concurrent review to evaluate the medical necessity and efficiency of services for its 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 June 3, 2025, through June 20, 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 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 Intervention Services: 14 member samples were reviewed for evidence of mobile crisis assessments, progress notes, and safety plans.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Eight member referrals from the MCP to the Mental Health Plan (MHP) and 15 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

Member Telehealth Consent: Six verbal and six written telehealth consent samples were reviewed for evidence of documentation of verbal or written telehealth consent prior to the initial delivery of telehealth services.

Category 5 – Coverage and Authorization of Services

Treatment Authorizations: 14 member files were reviewed for evidence of appropriate treatment authorization including the concurrent review authorization process.

Category 7 – Program Integrity

There were no verification studies conducted for the audit review.

COMPLIANCE AUDIT FINDINGS

Category 2 – Care Coordination and Continuity of Care

2.3 Screening and Transition of Care Tools

2.3.1 Referrals and Coordination of Care

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

If a beneficiary shall be referred by the MHP to the MCP based on the score generated by the MHP's administration of the Adult or Youth Screening Tool, MHPs shall coordinate beneficiary referrals with MCPs or directly to MCP providers delivering NSMHS. MHPs may only refer directly to an MCP provider of NSMHS if P&Ps have been established and MOUs are in place with the MCP to ensure a timely clinical assessment with an appropriate in-network provider is made available to the beneficiary. Referral coordination shall include sharing the completed Adult or Youth Screening Tool and following up to ensure a timely clinical assessment has been made available to the beneficiary. Beneficiaries shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice. (BHIN 22-065, Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services)

After the Transition of Care Tool is completed, the beneficiary shall be referred to their MCP, or directly to an MCP provider delivering NSMHS if appropriate processes have been established in coordination with MCPs consistent with BHIN 22-011 and APL 22-005, or subsequent updates. MHPs shall coordinate beneficiary care services with MCPs to facilitate care transitions or addition of services, including ensuring that the referral process has been completed, the beneficiary has been connected with a provider in the new system, and the new provider accepts the care of the beneficiary, and medically necessary services have been made available to the beneficiary. All appropriate consents shall be obtained in accordance with accepted standards of clinical practice. (BHIN 22-065, Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services)

Plan Policy *No. CLIN 318, Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (Effective Date: 02/21/2023)*, stated that MHPs shall coordinate member care services with MCPs to facilitate care transitions or addition of services, including ensuring that the referral process has been completed, the member has been connected with a provider in the new system, and the new provider accepts the care of the member, and medically necessary services have been made available to the member.

Plan's *Memorandum of Understanding (MOU) Amendment No. 2 to the Master Administration Services Agreement between Partnership Health Plan of California and Siskiyou County (Dated 07/01/2020)*, stated the contractor shall comply with the care and coordination requirements and shall implement procedures to deliver care to and coordinate services for all of its members such as with the services the member receives from any other managed care organization.

Finding: The Plan did not coordinate care and complete MCP referrals by ensuring timely clinical assessments and medically necessary services were made available to members.

In a verification study, nine of 15 member records showed that the Plan did not ensure the completion of MCP referrals. After members were referred to the MCP or directly referred to the MCP's providers, there were no records of the Plan's follow-up attempts to ensure the provision of a timely clinical assessment or that medically necessary services were made available to members.

In an interview, the Plan stated that they utilized the Siskiyou Closed Loop Referral Report to track referrals with their MCP. While the Plan indicated that they perform MCP referral follow-up, verification study samples did not reveal documentation that follow-up attempts were made to ensure members received medically necessary services. The Plan confirmed in a narrative, "we do not have further documentation around follow-up on members referred." Additionally, the Plan stated that losing their Quality Assurance Manager (QAM) during the audit period negatively impacted their daily operations, and they were not performing the oversight needed to monitor the referrals effectively.

When the Plan does not follow up to ensure care coordination and completion of MCP referrals, it can lead to missed or delayed timely assessments and medically necessary services for members.

Recommendation: Implement policies and procedures to ensure coordination and completion of MCP referrals by ensuring timely clinical assessments and medically necessary services are made available to members.

COMPLIANCE AUDIT FINDINGS

Category 4 – Access and Information Requirements

4.4 Telehealth Member Consent

4.4.1 Verbal Consent for Telehealth Services

The Plan is required to comply with all state and federal statutes and regulations, the terms of the contract, with BHINs, and any other applicable authorities. *(Contract, Exhibit E, section (6)(H))*

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 beneficiaries:

- The beneficiary 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 beneficiary'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 beneficiary's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. The beneficiary's consent must be documented in their medical record and made available to DHCS upon request. A provider may utilize a general consent agreement to meet this documentation requirement if that general consent agreement: 1) specifically mentions the use of telehealth delivery of covered services; 2) includes the information described above; 3) is completed prior to initial delivery of services; and 4) is included in the beneficiary record. (BHIN 23-018, Updated Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal)

The Plan may delegate duties and obligations to subcontracting entities if the Plan determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. The Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the DHCS, notwithstanding any

relationship(s) that the Plan may have with any subcontractor. *(Contract, Exhibit A, Attachment 1, section 3; Title 42 of Code of Federal Regulations (CFR) section 438.230(b)(1))*

Plan policy *CLIN 317, Providing Behavioral Health Services Via Telehealth (Effective Date: 02/22/2023),* stated that prior to initial delivery of covered services via telehealth or telephone, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services and will explain all required information elements in accordance with BHIN 23-018.

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

A verification study revealed that six of six member records did not document verbal telehealth consent for three of four required elements listed in BHIN 23-018. There is no documentation of an explanation for the following elements:

- Members have the 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 member for future Medi-Cal services.
- Non-medical transportation benefits are available for in-person visits.

In an interview, the Plan indicated that the missing elements in the verbal telehealth consent documentation were due to a lack of provider training and oversight from the Plan. In addition, the Plan's QAM was vacant during the audit period, which adversely impacted its daily operations. The Plan acknowledged the necessity of educating and training its providers to ensure that the telehealth consent will comply with all the requirements outlined in BHIN 23-018.

When the Plan does not ensure that all providers are appropriately obtaining and documenting verbal or written telehealth consent before rendering telehealth services to members, it can result in members making poor health decisions due to a lack of adequate knowledge about treatment options.

Recommendation: Implement policies and procedures to ensure all providers explain and document all required elements listed in BHIN 23-018 when collecting verbal telehealth consents prior to the delivery of telehealth services.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.2 Concurrent Review and Prior Authorization Requirements

5.2.1 Concurrent Review of Psychiatric Inpatient Services

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

The Plan's UM Program must evaluate medical necessity, appropriateness, and efficiency of services provided to Medi-Cal members prospectively, such as through prior or concurrent authorization review procedures. The concurrent review authorization process applies to all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals, and PHFs (Psychiatric Health Facility Services) certified by DHCS as Medi-Cal providers of inpatient hospital services. *(BHIN 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and PHFs)*

The Plan may delegate duties and obligations to subcontracting entities if the Plan determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. The Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the Department, notwithstanding any relationship(s) that the Plan may have with any subcontractor. *(Contract, Exhibit A, Attachment 1, section 3; Title 42 of Code of Federal Regulations section 438.230(b)(1))*

Plan policy *CLIN 313 Utilization Management (effective 06/24/2022)*, stated that with oversight from the QAM, the Behavioral Health Department shall have any decision to deny a service authorization request or to authorize a service in amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in addressing the member's behavioral health needs.

Contract Agreement *1124-PICR-2022 SK, with California Mental Health Services Authority ("CalMHSA") (01/01/2022 – 12/31/2024)*, stated its subcontractor shall conduct concurrent review for all psychiatric hospital and PHFs on behalf of the Plan.

Subcontractor policy *Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility (revised 5/7/2024)* outlined the process for evaluating medical necessity, appropriateness, and efficiency of services provided to Medi-Cal members prospectively, such as through prior or concurrent authorization review procedures.

Finding: The Plan did not implement a UM Program to ensure its subcontractor performed a concurrent review to evaluate the medical necessity and efficiency of services for its members.

In a verification study, nine of 14 members' treatment authorizations for services did not show evidence of a concurrent review since documentation showed authorizations were conducted retrospectively. Documentation showed that the inpatient hospitals demonstrated a pattern of not notifying the Plan's subcontractor responsible for concurrent review. This resulted in the non-implementation of the Plan's policies and procedures for concurrent review.

The Plan did not demonstrate ongoing training instructing inpatient hospitals to notify the Plan's subcontractor responsible for concurrent review. The Plan did not submit the requested evidence of training regarding concurrent review requirements.

In an interview, the Plan stated it lacked internal controls to verify whether its subcontractor performed concurrent review. The QAM position, which was responsible for overseeing authorization, was vacant during the audit period, making monitoring difficult. The Plan admitted it did not hold regular meetings with the subcontractor or keep records of oversight activities.

When the Plan does not oversee its subcontractor responsible for concurrent review and does not make available training on provider responsibilities, it cannot ensure implementation of a UM program that prospectively evaluates the medical necessity and appropriateness of in-hospital stays. This can lead to increased costs due to unnecessary services and potential patient harm from delayed or inappropriate care.

Recommendation: Implement policies and procedures to ensure the Plan's UM Program performs concurrent review to evaluate the medical necessity and efficiency of services for its members.