DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

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

Contract Number: 22-20122

Contract Type: Specialty Mental Health Services

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

Dates of Audit: March 11, 2025 — March 21, 2025

Report Issued: July 23, 2025

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I. INTRODUCTION

Placer 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.

Placer County is located in the northern part of the state. The Plan provides services within the unincorporated county and in six cities: Auburn, Colfax, Lincoln, Roseville, Rocklin, and Loomis.

As of March 2025, the Plan had a total of 3,424 members receiving services and a total of 96 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 March 11, 2025, through March 21, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held July 9, 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 July 17, 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, 2018, through June 30, 2021, identified deficiencies incorporated in the Correction Action Plan (CAP). The prior year CAP was completely closed at the time of onsite. This year's 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

The Plan is required to obtain member consent including criteria outlined in BHIN 23-018 prior to initial delivery of covered services via telehealth. The Plan did not ensure all providers obtained member consent including criteria outlined in BHIN 23-018 prior to initial deliver of covered services via telehealth.

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

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 March 11, 2025, through March 21, 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 Plan representatives.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

Mobile Crisis Intervention Services: Ten 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: Ten member referrals from the Managed Care Plan (MCP) to the Mental Health Plan (MHP) and ten 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

Beneficiary Telehealth Consent: Six member samples were reviewed for evidence of documentation of oral or written telehealth consent prior to the initial delivery of telehealth services.

Category 5 – Coverage and Authorization of Services

Service Authorizations: Ten member files were reviewed for evidence of appropriate service authorization request.

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

Category 6 – Member Rights and Protection

Grievance Procedures: 15 grievances 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.

COMPLIANCE AUDIT FINDINGS

CATEGORY 4 ACCESS AND INFORMATION REQUIREMENTS

4.4 Telehealth Member Consent

4.4.1 Telehealth Consent Requirements

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

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 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; and 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 in Medi-Cal)*

The Plan must document the member's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. The member'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 specifically mentions the use of telehealth delivery of covered services; includes the information described in this BHIN; is completed prior to initial delivery of services; and is included in the member record. *(BHIN 23-018, Updated Telehealth Guidance for Specialty Mental Health Services in Medi-Cal)*

Plan policy *SP 655, Telehealth and Telephone Services (revised 10/12/2023)* stated that prior to delivery of telehealth services, providers are required to obtain written telehealth consent using the *Placer County Systems of Care Telehealth & Telephone Services Consent* form or may receive verbal consent if the consent includes the

criteria outlined in BHIN 23-018 and is documented in the member's electronic health record.

Plan monitoring tool *SMHS Utilization Review Audit Tool FY 23-24* includes the assessment and validation of members' medical records to ensure documented verbal or written telehealth consent, including criteria outlined in BHIN 23-018, prior to initial delivery of telehealth services when telehealth services are provided to members.

Finding: The Plan did not ensure all providers obtained member consent including criteria outlined in BHIN 23-018 prior to initial deliver of covered services via telehealth.

Plan policy *SP 655, Telehealth and Telephone Services (revised 10/12/2023)* and monitoring tool *SMHS Utilization Review Audit Tool FY 23-24* reflected the requirements and expectations in BHIN 23-018; the policy lacked an effective process for evaluation and remediation of noncompliant telehealth consents.

A verification study of medical records revealed that two out of six members' records reviewed did not contain any of the appropriate telehealth consent elements, as required in BHIN 23-018 prior to the initial delivery of telehealth services.

- A member received telehealth services on August 8, 2023; no evidence of written or verbal telehealth any consent was included in the member's records.
- A member received telehealth services on September 18, 2023, the member's record indicated verbal consent was obtained; however, no evidence of any notification of provisions of telehealth services.

In an interview, the Plan stated that it identified telehealth deficiencies in its 2023-2024 chart audits. The Plan used the SMHS Utilization Review Audit Tool FY 2023-2024 which included multiple elements of chart compliance analysis, including, but not limited to telehealth consent documentation requirements. Telehealth documentation deficiencies contributed to chart audit compliance percentages of 40 percent for the Plan providers and 53 percent for the Plan's contracted providers. Telehealth deficiencies included failure to provide evidence of telehealth health consent criteria outlined in BHIN 23-018. In a written statement the Plan explained that low documentation compliance among its providers were discussed with leadership; however, the Plan did not submit evidence of discussions with leadership, corrective actions, or trainings to address telehealth consent deficiencies during the audit period.

When the Plan does not correct non-compliance with telehealth consent requirements, it cannot ensure that all providers are appropriately obtaining and documenting all mandatory verbal or written consent components before rendering telehealth services. This can result in members making poor health decisions due to lack of adequate knowledge about treatment options.

Recommendation: Implement policies and procedures to ensure all providers obtain member consent prior to the initial delivery of covered services via telehealth.