

DHCS AUDITS AND INVESTIGATIONS  
CONTRACT AND ENROLLMENT REVIEW DIVISION  
SAN DIEGO SECTION

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

Contract Number: 22-20100

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2024 — June 30, 2025

Dates of Audit: October 6, 2025 — October 17, 2025

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## I. INTRODUCTION

El Dorado County Behavioral Health (Plan) is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) to provide mental health services to county residents.

El Dorado County is located in northern California. The Plan provides services within the unincorporated county and in two cities: Placerville and South Lake Tahoe.

As of August 2025, the Plan had a total of 1,799 members receiving services.

## 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 October 6, 2025, through October 17, 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 March 11, 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 March 11, 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 five categories of performance: 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 (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 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 provide a statewide, toll-free telephone number 24 hours a day, seven days a week, that provides information to members about how to access Specialty Mental Health Services (SMHS). Finding 4.2.1: The Plan did not ensure its 24/7 Access Line provided required information to members about how to access SMHS and how to use the member problem resolution and Fair Hearing processes.

The Plan is required to maintain a written log of initial requests from members. Finding 4.2.2: The Plan did not ensure its written log contained all initial requests from members.

The Plan is required to obtain member consent including criteria outlined in *Behavioral Health Information Notice (BHIN) 23-018, Updated Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal* (dated 04/25/2023), prior to initial delivery of covered services via telehealth. Finding 4.4.1: The Plan did not ensure that member telehealth consents included all required criteria outlined in BHIN 23-018.

## **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 SMHS Contract.

### PROCEDURE

DHCS conducted an audit of the Plan from October 6, 2025, through October 17, 2025, for the audit period of July 1, 2024, through June 30, 2025. 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 2 – Care Coordination and Continuity of Care**

Coordination of Care Referrals: Twelve member referrals from the Managed Care Plan (MCP) to the Mental Health Plan (MHP) and 12 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**

Access Line Test Calls: Three test calls requesting information about SMHS, three test calls requesting how to treat an urgent condition, and two test calls requesting information about the member problem resolution and Fair Hearing processes were made to the Plan's statewide 24/7 toll-free number to confirm compliance with regulatory requirements.

Access Line Test Call Log: The Plan's call log was reviewed to ensure all required log components were documented for five test calls made to the Plan.

Beneficiary Telehealth Consent: Ten member 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**

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

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

## **Category 6 – Beneficiary Rights and Protection**

Grievance and Appeal Procedures: Five grievances and one appeal 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

### 4.2 24/7 Access Line and Written Log of Requests for Specialty Mental Health Services

#### 4.2.1 Toll-Free Access Line

The Plan shall provide a statewide, toll-free telephone number 24 hours a day, seven days a week, that provides language capabilities in languages spoken by members of the county; provides information to members about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met; services needed to treat a member's urgent condition; and how to use the member problem resolution and Fair Hearing processes. (*California Code of Regulations, Title 9, chapter 11, section 1810.405(d); and section 1810.410(e)(1)*)

Plan policy, *M-157 24/7 Access/Crisis Lines; Call Documentation; and Availability of 24/7 Services* (revised 8/11/2022), states the Plan provides a statewide, toll-free telephone number 24 hours a day, seven days a week. The Plan's 24/7 access/crisis lines are responsible for providing the following information to all callers: how to access services, services needed to treat a beneficiary's urgent condition, how to use the beneficiary problem resolution and State Fair Hearing processes, and how to access additional community resources and/or emergency services.

**Finding:** The Plan did not ensure its 24/7 Access Line provided the required information regarding how to access SMHS or how to use the member problem resolution and Fair Hearing processes.

The DHCS audit team conducted six test calls to the Plan's 24/7 toll-free number between December 1, 2024, and March 16, 2025. The test calls evaluated multiple criteria. The audit found the following noncompliance:

- In one of six test calls, the Plan did not provide information to members about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met.
- In two of six test calls, the Plan did not provide information on the member problem resolution process.

Plan policy M-157 stated that the Plan monitors the effectiveness of the Access Line through periodic test calls and documentation reviews. Documentation reviews involve the Plan staff periodically conducting random checks of the Access Log to ensure that the required documentation is being completed by both daytime and after-hours staff. Any urgent issues identified should be addressed by the Plan's management team. The policy also stated that the Plan's Quality Improvement Committee (QIC) reviews test calls and Access Log data at QIC meetings to mitigate identified issues and ensure compliance. In a written narrative, the Plan confirmed it did not have documentation of these monitoring procedures occurring during the audit period.

Plan policy M-157 also stated that the Plan will provide, at least semi-annually, training to staff and contracted providers responsible for the 24/7 Access Line. However, the Plan lacked documented evidence confirming that staff training took place during the audit period. In a written narrative, the Plan acknowledged that formal training was not provided to its staff or contracted provider. The Plan also confirmed that its call script was not shared with the contracted provider.

In the Plan's prior triennial review for the audit period of July 1, 2021, through June 30, 2022, DHCS determined that the Plan was in partial compliance with requirements for providing information to members via its 24/7 toll-free number. The Plan's CAP outlined action items to address the finding, including staff training, updating call scripts and policies, conducting regular test calls with various scenarios, and implementing monthly reviews through the QIC agenda and documentation. The Plan did not implement adequate monitoring and training mechanisms to ensure that its 24/7 Access Line met regulatory and policy requirements.

When the Plan does not provide required information, members may not receive timely or accurate information, resulting in delayed or missed access to behavioral health services and increased risk of adverse outcomes.

**This is a repeat finding of the prior review (Fiscal Year 2021/2022) – 24/7 Toll-Free Telephone Information Requirements.**

**Recommendation:** Implement policy and procedures to ensure its 24/7 Access Line consistently provides members with the required information on accessing SMHS and member problem resolution and Fair Hearing procedures.

## 4.2.2 Logging of Specialty Mental Health Services Requests

The Plan shall maintain a written log of the initial requests for SMHS from beneficiaries. The requests shall be recorded whether they are made via telephone, in writing, or in person. The written log shall contain the name of the beneficiary, the date of the request, and the initial disposition of the request. (*California Code of Regulations, Title 9, section 1810.405(f)*)

Plan policy, M-157 *24/7 Access/Crisis Lines; Call Documentation; And Availability of 24/7 Services* (revised 8/11/2022), stated that all requests for services, received via the 24/7 access/crisis lines, in person, or in writing, must be logged in the electronic Request for Services List/Access Log and/or in a Pre-Admit record. State law requires that the Plan logs at least the following information: the caller's first and last name, the date of the request, and the initial disposition of the request.

**Finding:** The Plan did not log all member calls requesting SMHS.

The DHCS audit team conducted six test calls to the Plan's 24/7 toll-free number between December 1, 2024, and March 16, 2025. However, two of the test calls pertained to the member problem resolution process, which does not constitute an initial request for SMHS and therefore does not require documentation in the Plan's written log. The review of the Plan's written logs revealed that none of the remaining four test calls were documented.

Plan policy M-157 stated that the Plan monitors the effectiveness of the Access Line through periodic test calls and documentation reviews. Documentation reviews involve Plan staff periodically conducting random checks of the Access Log to ensure that the required documentation is being completed by both daytime and after-hours staff. Although the Plan reports test call results quarterly to DHCS, the Plan did not provide evidence that the test calls were reviewed, analyzed, or addressed by management. In a written narrative, the Plan confirmed it did not have documentation of these monitoring procedures occurring during the audit period.

Plan policy M-157 also stated that the Plan will provide, at the minimum, semi-annual training to staff and contracted providers responsible for the 24/7 Access Line. However, the Plan lacked documented evidence of staff training during the audit period. In a written narrative, the Plan acknowledged that formal training was not provided to its staff or its contracted provider. A review of the call script utilized by the Plan revealed that it did not contain any guidance on how to document calls.

In the Plan's prior triennial review for the period of July 1, 2021, through June 30, 2022, DHCS determined that the Plan was in partial compliance with requirements to maintain a written log(s) of initial requests for SMHS. Subsequently, the Plan's CAP outlined action items to address the finding, including the implementation of a new Access Log template, a new intake process, updating policies, staff training, conducting test calls, and implementing monthly reviews through the QIC agenda and documentation. The Plan did not implement adequate monitoring and training mechanisms for documenting all incoming member calls requesting SMHS.

Failure to document the required elements of member service requests may result in delayed or missed access to medically necessary mental health services. It can also result in reduced accountability in responding to the needs of members.

**This is a repeat finding of the prior review (Fiscal Year 2021-2022) – Written Log of Requests for SMHS**

**Recommendation:** Revise and implement policies and procedures to ensure that all member calls requesting SMHS are logged.

## 4.4 Telehealth Requirements

### 4.4.1 Telehealth Consent Form

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)*)

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; Code of Federal Regulations, Title 42, section 438.230(b)(1)*)

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 criteria 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 document the member's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. 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 *BHIN 23-018, Updated Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal* (dated 04/25/2023); is completed prior to initial delivery of services and is included in the member record.

**Finding:** The Plan did not ensure that member telehealth consents included all required criteria.

In a verification study, ten of ten member telehealth consents did not include the required criteria outlined in BHIN 23-018, as follows:

- In seven written consents obtained, the availability of Non-Medical Transportation benefits for in-person visits was not documented.
- In three verbal consents obtained, the right to access covered services in person, the use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time, and the availability of Non-Medical Transportation benefits for in-person visits was not documented.

In an interview, the Plan confirmed that during the audit period, it did not have a formal policy or procedure outlining telehealth services and the associated informed consent process. The Plan also acknowledged that its written Telehealth Consent Form lacked the element addressing the availability of Non-Medical Transportation benefits. The Plan's written Telehealth Informed Consent Form is also utilized by its subcontracted providers. For verbal consents, the Plan also relies on a progress note template to document verbal telehealth informed consent. The progress note template only addresses the limitations or risks of receiving services via telehealth. All other required elements are not addressed in the progress note template.

Additionally, the Plan monitors the telehealth informed consent process through a chart auditing tool. However, the tool only monitors whether telehealth informed consent has been obtained prior to the delivery of services. It does not specifically monitor whether all required elements of telehealth consent are explained to beneficiaries. Subsequently, the Plan's monitoring process failed to identify the inadequate telehealth consents obtained.

When the Plan does not fully inform members of their rights regarding the use of telehealth services, there is a risk of potential patient harm when members are not aware of access to other treatment modalities.

**Recommendation:** Implement a policy to ensure that verbal and written telehealth consents include all required criteria.