DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

LOS ANGELES SECTION

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

Contract Number: 22-20113

Contract Type: Specialty Mental Health Services

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

Dates of Audit: August 26, 2025 — September 9, 2025

Report Issued: January 6, 2026

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I. INTRODUCTION

Mariposa 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.

Mariposa County is located in central California. The Plan is one of three counties that does not include any incorporated cities. The county encompasses the unincorporated community of Mariposa, which serves as the administrative center, along with 17 other communities recognized as census-designated places.

As of June 2025, the Plan had a total of 665 members receiving services and a total of 56 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 August 26, 2025, through September 9, 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 December 15, 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 December 18, 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 Corrective Action Plan (CAP). The prior year CAP was closed at the time of the onsite visit. 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

There were no findings noted for this category during the audit period.

Category 4 – Access and Information Requirements

Finding 4.2.1: The Plan is required to provide a statewide, toll-free telephone number available 24 hours a day, 7 days a week. The access line must provide information about how to access Specialty Mental Health Services (SMHS) (including services required to assess medical necessity), assistance for urgent conditions, and guidance on the member problem resolution and fair hearing processes. The Plan did not ensure its 24/7

access line provided the required information it must make available to members, such as how to access SMHS services (including services required to assess medical necessity) and guidance on the member problem resolution and fair hearing processes.

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 6.5.1: The Plan is required to accurately maintain a grievance log and record grievances within one working day of the date of receipt. The Plan did not maintain an accurate grievance log that recorded grievances 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 SMHS Contract.

PROCEDURE

DHCS conducted an audit of the Plan from August 26, 2025, through September 9, 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 1 – Network Adequacy and Availability of Services

Mobile Crisis Services Benefit: Ten medical records were reviewed for the provision of services.

Category 2 – Care Coordination and Continuity of Care

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

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

Treatment Authorizations: Ten inpatient treatment facility 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.

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 Toll-Free Telephone Number

4.2.1 Telephone Access Line

The Plan shall provide a statewide, toll-free telephone number available 24 hours a day, 7 days a week. The access line must provide language capabilities in all languages spoken by county members, information about how to access SMHS (including services required to assess medical necessity), assistance for urgent conditions, and guidance on the member problem resolution and fair hearing processes. *(California Code of Regulations, Title 9, Chapter 11, sections 1810.405(d) and 1810.410(e)(1))*

Plan policy, *24/7 Access Line* (revised 07/31/2024), stated that a statewide toll-free telephone number, available 24 hours a day, 7 days a week, will provide members with information on accessing SMHS and substance use disorder services. The access line also assists with referrals, addressing emergent and urgent conditions, and guiding members through problem resolution and fair hearing processes. After-hours contractors are available to receive calls on the 24/7 access line outside of regular business hours from 5 p.m. to 8 a.m.

Finding: The Plan did not ensure its 24/7 access line provided the required information to members, such as how to access SMHS (including services required to assess medical necessity) and guidance on the member problem resolution and fair hearing processes.

In a verification study, seven test calls revealed the following:

- For five calls, callers were able to reach a live operator during business hours and were able to receive the required information that the Plan's 24/7 access line must make available to members.
- For two test calls after business hours, the callers were unable to reach a person or a live operator. Instead, callers were directed to the automated phone options. None of the automated options explicitly provided information about how to access SMHS (including services required to assess medical necessity) and guidance on the member problem resolution and fair hearing processes.

In an interview and a written statement, the Plan acknowledged that it did not provide guidance to inform its members of the option to reach a live operator after business hours. The Plan stated that after business hours, members could access an automated

system that included an option 2/Crisis Line. This option would allow members to reach a live operator who could give the required information that the Plan's 24/7 access line must make available to members.

The Plan conducts test calls to ascertain that its 24/7 toll-free phone line complies with contract requirements. Review of the test call results showed that the Plan did not identify a weakness in its automated phone system. Specifically, the phone tree did not provide guidance to members on how to reach a live operator after business hours.

If the Plan does not ensure its toll-free telephone number provides the required information, members may experience confusion or difficulty navigating available mental health services and information. This can lead to delays in care and unmet treatment needs.

Recommendation: Implement policy and procedures to ensure that the Plan's toll-free telephone number provides all required information for members.

COMPLIANCE AUDIT FINDINGS

Category 6 – Beneficiary Rights and Protection

6.1 Handling of Grievances

6.1.1 Grievance Log Accuracy

The Plan is required to maintain a grievance log and record grievances within one working day of the date of receipt of the grievance. The grievance log must include the date received and be accurately maintained in a manner accessible to the DHCS and available upon request. (*Contract, Exhibit A, Attachment 12, 2(A)(F))*

Plan policy, *Grievance and Appeals* (revised 11/06/2024), stated that the Quality Assurance Supervisor or designee will ensure that all complaints (grievances, appeals, expedited appeals) are logged in the Grievance/Appeal Log within one business day of receipt.

Finding: The Plan did not maintain an accurate grievance log that recorded grievances within one working day of the date of receipt.

In a verification study, four of ten grievance records showed that the Plan did not maintain an accurate grievance log, as the grievance log date occurred more than one day after the grievance receipt date. Logging delays ranged between two to four weeks from the date the Plan received grievances.

In an interview, the Plan acknowledged that it lacks a process to monitor compliance with its policies and procedures to ensure accuracy of logging grievances.

In a written narrative, the Plan stated that Quality Assurance currently monitors the log to ensure grievances are processed timely. However, Quality Assurance does not compare the hard copy grievance forms with the log and therefore did not identify the deficiencies.

When the Plan does not monitor to ensure maintenance of an accurate grievance log, grievances may not be resolved within the required timeframes, resulting in delayed services provided to members.

Recommendation: Revise policy and procedures to ensure the grievance log is accurately maintained with grievances recorded within one working day of the date of receipt.