

DHCS AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SUBSTANCE USE DISORDER REVIEW SECTION

**REPORT ON THE SUBSTANCE USE DISORDER
(SUD) AUDIT OF LOS ANGELES COUNTY
FISCAL YEAR 2025-26**

Contract Number: 23-30110

Contract Type: Drug Medi-Cal Organized Delivery System (DMC-ODS)

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

Dates of Audit: October 7, 2025 — October 17, 2025

Report Issued: May 4, 2026

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I. INTRODUCTION

Los Angeles 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 substance use disorder services to county residents.

Los Angeles County is located in the southwest region of California. The Plan provides services within the unincorporated county and in the cities of Los Angeles, Long Beach, Santa Clarita, and Glendale.

As of October 1, 2025, the Plan had a total of 22,172 Medi-Cal members receiving DMC-ODS services and a total of 220 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 October 7, 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 April 13, 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 April 28, 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: Availability of Drug Medi-Cal Organized Delivery System (DMC-ODS) Services, Quality Assurance and Performance Improvement, Coverage and Authorization of Services, Beneficiary Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2023, through June 30, 2024, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year's 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 – Availability of Drug Medi-Cal Organized Delivery System Services

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

Category 3 – Quality Assurance and Performance Improvement

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

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

The Plan is required to acknowledge receipt of each grievance and appeals of Adverse Benefit Determinations within five calendar days. Finding 6.2.1: The Plan did not ensure that written letters of acknowledge were provided to members within five calendar days of receipt.

The Plan requires maintaining records of grievances and appeals for ongoing monitoring and updates. Each record should include the reason, dates of receipt and review, resolutions, and the names of the individuals involved. These records must be accessible and available to the Department and Centers for Medicare & Medicaid Services (CMS) upon request. Finding 6.2.2: The Plan did not maintain accurate records of grievances and appeals, including dates received, reviews, and resolutions at each level.

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 DMC-ODS Contract.

PROCEDURE

DHCS conducted an audit of the Plan from October 7, 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 1 – Availability of Drug Medi-Cal Organized Delivery System Services

There were no verification studies conducted for the audit review.

Category 3 – Quality Assurance and Performance Improvement

There were no verification studies conducted for the audit review.

Category 5 – Coverage and Authorization of Services

There were no verification studies conducted for the audit review.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: One grievance regarding the quality of care and five grievances regarding the quality of service were reviewed for timely resolution, an 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 6 – Beneficiary Rights and Protection

6.2 Handling of Grievance and Appeals

6.2.1 Grievance and Appeals Acknowledgements

The Plan shall have procedures for addressing beneficiary grievances and appeals of adverse benefits determinations shall include the acknowledgement of receipt of each grievance and appeal within five calendar days. (*Exhibit A, Attachment I, section II Federal Requirements, G, 3, ii, a*)

The acknowledgement letter shall include the date of receipt, name of representative to contact, telephone number of contract representative and address of Plan. The written acknowledgment to the beneficiary must be postmarked within (5) calendar days of receipt of the grievance. (*Mental Health and Substance Use Disorder Services Information Notice (MHSUDS IN) 18-010E, Federal Grievance and Appeal System Requirements with Revised Beneficiary Notice Templates*)

Plan policy *Substance Use Disorder Treatment Services Provider Manual – Version 9.0 (effective October 2024)* displays a Grievance Timeline Table that states written acknowledgement of receipt is within five (5) calendar days of receipt of the grievance. The policy further specifies that a written acknowledgment of receipt and a written notification of the decision regarding the grievance will be provided within the timeframes outlined in the aforementioned table.

Finding: The Plan did not ensure that written letters of acknowledgement were provided to members within five calendar days of receipt.

The Plan submitted a training document: *Agenda Notes Investigative Process*, for staff reviewing grievances and appeals. While the document referenced samples, site visit plans, and resolution letters, it did not require notice to members to include a written acknowledgment of receipt for each grievance and appeal to be sent within five calendar days.

In a verification study, it was found that none of the six members' grievance documentation in the sample included a written acknowledgment of receipt. In the case of all six grievances in the Plan's Data Universe, the grievances had a receipt date and a

resolution date. However, despite these dates being recorded, the documentation was incomplete as it lacked a written acknowledgment of receipt.

In an interview, the Plan stated that acknowledging a grievance or appeal was an informal process, in that phone correspondence with the complainant served as an acknowledgment. The Plan stated that grievance or appeal formal acknowledgment letters would be an administrative burden for residential programs to receive on an ongoing basis. The Plan also expressed concerns about each program receiving formal complaints against the program's staff or processes. The Plan stated that the process of documenting the date that the grievance or appeal was received in the resolution letter served as an acknowledgment. Also, the Plan stated that dates are manually logged and resolution letters are reviewed by different staff before finalization. The discrepancies between the log dates and the documentation are due to the actual dates when review notes were added and to possible back-and-forth revisions between managers and supervisors.

When a member and their representative are not formally advised that their grievance or appeal has been received according to the Plan's procedures, neither they nor the representative has a documented record or receipt, and a Plan representative for follow-up contact. The absence of formal acknowledgement letters impedes the member's access and full participation in the grievance process.

Recommendation: Implement policies and procedures to ensure staff acknowledge receipt of each grievance and appeal within five calendar days.

6.2.2 Recordkeeping Requirements

The Plan shall maintain comprehensive records of grievances and appeals and shall review this information as part of its continuous monitoring procedures, as well as for updates and revisions to the Department's quality strategy. The Plan must maintain detailed records of grievances and appeals, including the reason, dates of receipt and review, resolutions, and the names of the individuals involved. These records must be accessible and available to the Department and CMS upon request. (*Exhibit A, Attachment I, Section II Federal Requirements, G, 7*)

Plan policy *Substance Use Disorder Treatment Services Provider Manual – Version 9.0 (October 2024)* outlines procedures for grievances and appeals, including the timing for filing, written acknowledgement of receipt, the date received, as well as contact information for the County. Additionally, the policy specifies that upon receipt, Plan staff

will log the appeal and send a receipt notification to the requesting party within the established timeframes.

Finding: The Plan did not demonstrate compliance with maintaining accurate records of grievances and appeals, specifically including the date received, the date of each review or review meeting, and the date of resolution at each level.

The Plan submitted evidence of a grievance that occurred during the audit period for a member in residential treatment. The resolution letter dated December 19, 2024, with a receipt date of December 3, 2024. This grievance was not included in the Plan Data Universe of Grievance and Appeals (*FY 24-25 DMC-ODS SUBG Pre-Audit SUD Grievance and Appeals*) submitted with the initial evidence. Furthermore, DHCS reviewed evidence of another grievance that occurred during the audit period for a member in residential treatment. This grievance was listed in the Plan Data Universe of Grievance and Appeals (*FY 24-25 DMC-ODS SUBG Pre-Audit SUD Grievance and Appeals*) with a receipt date of November 18, 2024, and a resolution date of December 11, 2024. The actual resolution letter submitted as evidence notes a date of January 13, 2025, with a receipt date of November 13, 2024. The Plan's failure to document actions taken, missing grievance details, and resolution dates prior to the final resolution letter resulted in inaccuracies in grievance and appeal records.

In an interview, the Plan acknowledged that there are discrepancies in resolution dates. The Plan stated that dates are manually entered in the log and that different staff review resolution letters before finalizing them. The differences between the dates in the submitted log and the documentation can be attributed to the actual date when the review staff added their notes. The Plan also noted that there may have been some back-and-forth between managers and supervisors to finalize the actual resolution letter. The Plan stated that dates are manually logged and resolution letters are reviewed by different staff before finalization. The discrepancies between the log dates and the documentation are due to the actual dates when review notes were added and to possible back-and-forth revisions between managers and supervisors.

When the Plan does not document each review or review meeting for every grievance and appeal, the members and their representatives are not adequately informed about or advised of additional time-sensitive actions required to appeal an outcome, between informal correspondence and a resolution letter. Timely resolution of grievances and appeals ensures that members and their representatives understand their rights under Medi-Cal and how these rights may impact SUD treatment and outcomes. Furthermore,

the failure to document actions taken for filed grievances indicates insufficient monitoring of reporting requirements to DHCS.

Recommendation: Develop and implement policies and procedures to ensure records of grievance and appeals are accurately maintained and include all required information.