DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

[NORTH II SACRAMENTO SECTION]

REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) FOCUSED AUDIT OF HUMBOLDT COUNTY MENTAL HEALTH PLAN FISCAL YEARS 2022-23 AND 2023-24

Contract Number: 22-20103

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2022 — June 30, 2024

Dates of Audit: September 11, 2024 — October 15, 2024

Report Issued: June 12, 2025

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I. INTRODUCTION

Humboldt County Mental Health Plan (Plan) is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of providing specialty mental health services to county Medi-Cal members.

Humboldt County is located on the northwestern coast of California. The Plan provides services within the unincorporated county and in seven cities: Eureka, Arcata, Fortuna, Rio Dell, Ferndale, Blue Lake, and Trinidad. In addition, Humboldt County is home to eight federally recognized Native American Indian Tribes.

As of 2023, Humboldt County had 63,773 residents who were Medi-Cal members. A total of 3,628 members utilized SMHS services in 2023. The Plan provided SMHS and Drug Medi-Cal Organized Delivery System (DMC-ODS) treatment through 15 County owned and operated providers, 14 subcontracted organizational providers, and 3 contracted Indian Health Care Provider (IHCP) facilities. However, the focus of this report is entirely on the Plan's provision of SMHS.

DHCS' Behavioral Health Oversight and Monitoring Division (BHOMD) was informed of areas in which the Plan may not have been meeting legal and contractual requirements specific to standards for timely access to care and services, upholding member's rights, and appointment wait times. BHOMD also noted concerns regarding potential compliance issues with timely access to care, tracking and reporting of grievances, and access to care including tribal populations. Furthermore, tribal representatives in Humbolt had reached out to the Department with similar concerns of timely access, particularly for youth with high acuity needs during the audit period. As a result, DHCS' Audits and Investigations initiated a focused audit of the Plan.

An additional concern was noted due to litigation in which a member sued Humboldt County and named DHCS as a respondent. In October 2024, the case was dismissed. Although, separate and distinct from this focused audit engagement, the issues in the case contained similar themes of the Plan's inability to meet timely access standards.

II. EXECUTIVE SUMMARY

This report presents the audit findings of DHCS' focused audit for the period of July 1, 2022, through June 30, 2024. The focused audit was conducted from September 11, 2024, through October 15, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on May 21, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft focused audit findings. On June 06, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

A typical audit is comprised of seven categories: Network Adequacy and Availability of Services, Care Coordination and Continuity of Care, Quality Assurance and Performance Improvement, Access and Information Requirements, Coverage and Authorization of Services, Beneficiary Rights and Protections, and Program Integrity.

This focused audit, given the specific concerns, evaluated five of the seven 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 Beneficiary Rights and Protections.

The summary of the findings by category follows:

Category 1 – Network Adequacy and Availability of Services

The Plan is required to offer members appointments upon request that meet the timeframes defined in the timely access to care standards. The Plan did not meet timely access to care standards specific to children and youth members for non-urgent non-psychiatric initial appointments and urgent non-psychiatric initial appointments.

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

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

Category 5 – Coverage and Authorization of Services

The Plan must provide members with a written Notice of Adverse Benefit Determination (NOABD) if the Plan fails to provide services in a timely manner. The Plan did not ensure written NOABDs were provided to members when the Plan failed to provide services to members in a timely manner.

Category 6 – Beneficiary Rights and Protection

The Plan is required to maintain an accurate record of each grievance, which includes the date the grievance was received by the Plan. The Plan did not maintain an accurate record of each grievance; not all grievances reflected an accurate receipt date.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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 Mental Health Plan Contract.

PROCEDURE

DHCS conducted the focused audit of the Plan from September 11, 2024, through October 15, 2024, for the audit period of July 1, 2022, through June 30, 2024. The focused 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.

Following the issuance of the Compliance Audit Findings, the Plan will submit their Corrective Action Plan (CAP) to DHCS' Behavioral Health Oversight and Monitoring Division (BHOMD), unless otherwise noted below. BHOMD will monitor the Plan's progress towards timely completion of corrective actions and collect evidence of correction addressing findings of noncompliance. BHOMD will meet with the Plan for ongoing updates on CAP activities and provide technical assistance as appropriate to support CAP resolution.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

Children Services: Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) Determination: 14 children and youth who received initial assessments were examined to study the Plan's provision of services.

Category 2 – Care Coordination and Continuity of Care

Bi-Directional Referrals: 15 members' referrals were reviewed to examine the Plan's process for care coordination with Manage Care Plans.

Category 4 – Access and Information Requirements

24/7 Access Line and Written Log of Request for SMHS: 30 calls were reviewed for timely telephone screening by a qualified health professional or clinician.

Category 5 – Coverage and Authorization of Services

Notice of Adverse Benefit Determination: NOABD verification study samples for timely access to services were not available to review as the Plan did not issue any NOABDs for timely access delays during the audit period.

Category 6 – Beneficiary Rights and Protection

Grievances and Appeals: 23 grievances and two appeals were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for further review.

COMPLIANCE AUDIT FINDINGS

Category 1 – Network Adequacy and Availability of Services

1.1 AVAILABILITY OF SPECIALTY MENTAL HEALTH SERVICE

1.1.1 Timely Access to Appointments

The Plan is required to meet State standards for timely access to care and services, taking into account the urgency of the need for services. California Welfare and Institutions Code section 14197 (d) requires the Plan to comply with the appointment time standards set forth in California Health and Safety Code section 1367.03 and CCR, Title 28, section 1300.67.2.2. *(Behavioral Health Information Notice (BHIN) 24-020, 2024 Network Certification Requirements for County Mental Health Plans and Drug Medi-Cal Organized Delivery System Plans, BHIN 23-041, 2024 Network Certification Requirements for County Mental Health Plans and Drug Medi-Cal Organized Delivery System Plans, and BHIN 22-033, 2022 Federal Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS)*

The Plan is required to ensure that the network has adequate capacity and availability of licensed health care providers to offer members appointments that meet the following timeframes:

- Urgent care appointments for specialty mental health services that do not require prior authorization: within 48 hours of the request for appointment. appointment.
- Psychiatric services within 15 business days of the request for appointment.
- Outpatient non-urgent non-psychiatric specialty mental health services: within 10 business days of the request for appointment. (*BHIN) 24-020, 2024 Network Certification Requirements for County MHPs and DMC-ODS Plans)*

Plan policy *0704.520, Network Adequacy* (revised 08/16/2021), stated a member that called the Plan's 24/7 access line to request outpatient services must be offered an appointment within ten business days. A member with a written request for outpatient services must be contacted and offered an appointment within ten business days. A member with a written request for psychiatric services must be contacted and offered an appointment within 15 business days. A follow-up

appointment after the member receives an in-person assessment must be offered within ten business days.

Plan policy *0100.602, Urgent Conditions – Request for Treatment* (revised 11/30/2020), stated members who present an urgent condition to Plan's staff over the telephone are transferred (includes after hours and weekends) to the Crisis Stabilization Unit (CSU), for immediate response and triage. If crisis staff determine the members service need is urgent for outpatient services, then an initial assessment will be started by initiating a telephone screening process within 48 hours of the initial request.

Finding: The Plan did not meet timely access to care standards for appointments offered to members.

Prior to the start of the focused audit, DHCS had concerns regarding the Plan's compliance with their annual network certification reviews. Specifically, although the Plan's FY 2021-22 and FY 2022-23 data submissions indicated compliance with all applicable network adequacy standards for youth and adult members; DHCS had received concerns related to Humboldt's ability to provide timely access to care and services, which prompted DHCS to initiate the focused audit.

During the focused audit, the Plan self-disclosed in an interview that they had a number of members awaiting SMHS. In a subsequent response to DHCS' request for timely access tracking mechanisms, the Plan submitted their Children Youth and Family Services (CYFS) counseling referral log. In multiple interviews, the Plan explained the CYFS log was created by extracting data from the Plan's Electronic Health Record (EHR) systems and was used to assist in tracking members waiting for SMHS. The Plan also submitted their Timely Access Data Tool (TADT) that contained SMHS appointment data requested from July 1, 2022, through March 29, 2024.

A reconciliation of member appointment data contained within the CYFS log to the corresponding data noted within the TADT, confirmed that members did not receive offered appointments within timely access to care standards. A review of 30 children noted within the CYFS member referral log entries noted the following:

- Fourteen of 30 children did not receive offers for non-urgent non-psychiatric initial appointments within ten business days. The wait times to the offered appointments ranged from 20 to 130 business days.
- Two of 30 children did not receive an offer for an urgent non-psychiatric initial appointment within 48 hours. The wait times to the offered appointments ranged from 8 to 56 calendar days.

The Plan also discussed several reasons for the member referral log and timely access delays. The Plan stated that a lack of network providers and an increase in member referrals exceeded individual provider caseloads. The Plan also stated there was a lack of ability to track data to ensure timely access due to the conversion to a new EHR database that did not have all necessary functions to assist in recording and reporting appointment information.

When SMHS appointments are not provided to members within the timely access requirement timeframe, the members' health may be detrimentally affected while waiting longer than necessary to receive services.

Recommendation: Revise and implement policies and procedures to ensure the Plan meets timely access to care standards for appointments offered to members. Additionally, implement periodic evaluation of provider capacity to meet increasing demand for services. Work with DHCS on the interim corrective action plan (CAP) related to the waitlist elimination.

Interim CAP Implementation:

The Department, during the course of the audit, imposed a separate CAP due to the ongoing concerns regarding the Plan's ability to meet timely access standards as well as remediate the waitlist for youth. During the course of the CAP review, the Plan disclosed a separate waitlist for adult members. As a result, the scope of the CAP was expanded to address both youth and adult waitlists. As of April 18, 2025, the youth waitlist reduced to zero members, while the adult list has seen a slight increase. The Plan indicated a loss of clinicians for the adult system of care and are exploring remediating solutions, including the recruitment of more clinicians and the expansion of telehealth options.

To ensure access to care is sustained, DHCS and the Plan meet bi-weekly or as needed, and the Plan must continue to provide waitlist reports on a weekly basis for both youth and adult members until the Plan has sufficiently evidenced to DHCS that access to care can be ensured per all conditions of the CAP.

DHCS continues to provide technical assistance to the Plan regarding the data tracking and collection required not only to comply with the CAP, but also the crucial components necessary for future network compliance.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.4 NOTICE OF ADVERSE BENEFIT DETERMINATION

5.4.1 Issuance of Notice of Adverse Benefit Determination for Timely Access

The Plan shall provide a member with a NOABD under circumstances listed in the MHP Contract. One of the circumstances is the failure to provide services in a timely manner, as defined by the Department. *(MHP Contract, Ex. A, Att. 12, Section 10(A)(4))*

Adverse benefit determination can mean the failure to provide services in a timely manner, as defined by the State. *(Code of Federal Regulation (CFR), Title 42, section 438.400(b)(4))*

Members must receive a written NOABD and the "Your Rights" attachment when the Plan fails to provide service in a timely manner. The Plan must give members timely and adequate NOABD in writing. For decisions resulting in denial, delay, or modification of all or part of the requested services the Plan must mail the NOABD to the member within two business days of the decision. Additionally, the "Your Rights" attachment informs members of critical appeal and State Hearing rights. The corresponding, "Your Rights" attachments must be included when issuing a NOABD to a member. *(BHIN 22-070, Parity Requirements for Drug Medi-Cal (DMC) State Plan Counties) (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, *0704.500 Notice of Adverse Benefit Determination (NOABD)* (revised 04/18/2024), stated the Plan will send a Timely Access letter to the member when the Plan fails to provide services in a timely manner (ten business days from the initial request for services). The Timely Access letter will be sent to the member, and the provider shall be notified within 24 hours of the decision. The purpose of the NOABD is to advise the member of the Adverse Benefit Determination and to provide information about the member's right to appeal the decision.

Finding: The Plan did not ensure written NOABDs were sent to members when the Plan failed to provide services to members in a timely manner.

Review of the Plan's appointment tracking and monitoring system and NOABD log indicated that in instances noted during the audit period in which members were provided services beyond timely access standards, the Plan did not issue the required NOABD.

Although policy 0704.500 stated the Plan will send members a NOABD in a timely manner, the Plan did not send NOABDs when appropriate. The Plan confirmed in writing that it did not issue NOABDs for timely access delays during the audit period. In an interview, the Plan further admitted systemic oversight issues with the NOABD process, which included lack of monitoring controls. The Plan acknowledged the need for improved training and monitoring to address the issues.

When the Plan does not ensure that NOABDs were sent to members who did not receive services timely, members are not informed of their rights to appeal and may experience further delays in obtaining necessary services.

Recommendation: Implement policies and procedures to ensure NOABDs are issued to members who do not receive services within timely access standards and ensure all network providers are informed of and trained on the updated NOABD policies and procedures. Continue to work with DHCS on the existing CAP related to the NOABDs.

Interim CAP Implementation:

Based on the timely access standard delays, DHCS imposed an immediate CAP for the Plan to remediate the deficiency. The Plan provides updates to DHCS within its weekly waitlist reports pertaining to NOABD issuance and process improvement to ensure the Plan complies with all NOABD requirements, including evidence of training with staff on compliant use of NOABDs. DHCS provides technical assistance to the Plan during bi-weekly meetings on the CAP. The Plan's progress on appropriately revising and implementing NOABD policies and procedures will continue to be evaluated until the waitlists for both youth and adult SMHS have been remediated.

COMPLIANCE AUDIT FINDINGS

Category 6 – Beneficiary Rights and Protection

6.2 Handling Grievances and Appeals

6.2.1 Grievance Recording Accuracy

The Plan is required to maintain a log and record grievances within one working day of the date of receipt. *(MHP Contract, Ex. A, Att. 12, Section 2(A))*

The grievance record shall contain at a minimum, the date received and shall be accurately maintained in a manner accessible to the Department and available upon request. *(MHP Contract, Ex. A Att. 12 Section (2)(F))*

The Plan's policy, *0704.460 Client Problem Resolution Process* (revised 12/21/2023), stated that the Quality Improvement Coordinator or designee will enter the grievance into the log within one working day of receipt and provide a letter to the member acknowledging the receipt of the grievance within five calendar days of receipt.

Finding: The Plan did not ensure all grievances were recorded with the accurate receipt date.

The verification review of 23 grievance samples revealed two records with incorrect receipt dates.

The Plan did not have an adequate system to ensure the dates recorded within the grievance log were accurately noted as the date of receipt. Plan's policy 0704.460 did not clearly define procedures for the Plan to ensure all grievances recorded the accurate receipt date. Review of the Plan's grievance log revealed instances in which the date staff began reviewing the grievance was recorded, rather than the date received.

In an interview, the Plan acknowledged the receipt date should be recognized as the day the Plan initially received the grievance from a member, regardless of how long it took for the grievance to be internally processed and forwarded to the responsible staff.

When the Plan inaccurately reports the date of a grievance, the grievance and appeal process may not occur within the required timeframes. As a result, members may receive delayed services.

Recommendation: Revise policy and implement procedures to ensure that the date of a grievance is accurately recorded as the date received.