DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

[NORTH II SACRAMENTO SECTION]

REPORT ON THE SUBSTANCE USE DISORDER (SUD) FOCUSED AUDIT OF HUMBOLDT COUNTY DRUG MEDI-CAL – ORGANIZED DELIVERY SYSTEM (DMC-ODS) PLAN FISCAL YEAR 2022-23 AND 2023-24

Contract Number: 23-30106

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

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 DMC-ODS Plan (Plan) is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of providing SUD treatment services to county residents.

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, Humbolt County is home to eight Native American Indian reservations.

As of 2023, Humboldt County had 63,773 residents who were Medi-Cal members. A total of 1,061 members utilized DMC-ODS services in 2023. The Plan provided Specialty Mental Health Services and Drug Medi-Cal-Organized Delivery System (DMC-ODS) services through 15 county operated sites, 14 subcontracted organizational providers and 3 contracted Indian Health Care Providers (IHCP). Humboldt, as part of the DMC-ODS Regional Model, delegates the administration of the DMC-ODS program and, in some cases, the provision of SUD services to Partnership Health Plan of California (PHC). However, the focus of this report is entirely on Humboldt's obligation to ensure DMC-ODS service delivery is consistent with the terms of its contract with DHCS.

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 tribal population access to care. 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 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 focused 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 6, 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 Drug Medi-Cal Organized Delivery System (DMC-ODS) 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 three of seven categories of performance: Availability of DMC-ODS Services, Coverage and Authorization of Services, and Beneficiary Rights and Protection.

The summary of the findings by category follows:

Category 1 – Availability of Drug Medi-Cal Organized Delivery System Services

The Plan is required to ensure members seeking SUD treatment services are provided appointments timely, according to the timely access to care standards. The Plan did not ensure adult members who requested non-urgent DMC-ODS services were offered appointments timely.

Category 5 – Coverage and Authorization of Services

The Plan is required to ensure members receive a written Notice of Adverse Benefit Determination (NOABD) and the "Your Rights" attachment when the Plan fails to provide service in a timely manner. The Plan did not ensure NOABDs were issued to members who did not receive DMC-ODS services timely.

Category 6 – Beneficiary Rights and Protection

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

III. SCOPE/AUDIT PROCEDURES

SCOPE

DHCS' Contract and Enrollment Review Division conducted the focused 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 a 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). 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.

COMPLIANCE AUDIT FINDINGS

Category 1 – Availability of Drug Medi-Cal Organized Delivery System Services

1.1 AVAILABILITY OF DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM SERVICES

1.1.1 Timely Access to Non-urgent Appointments

The Plan shall ensure a non-urgent appointment with a non-physician substance use disorder provider within ten business days of the request for the appointment. *(DMC-ODS Contract, Ex. A, Att. I, Article II (C)(6)(i)(d)(6))*

The Plan is required to offer members appointments that meet the following timely access standards for DMC-ODS plans:

- Outpatient Services – Outpatient Substance Use Disorder Services: within ten business days of a request for services.
- Residential Services: within ten business days of request for services.
- Opioid Treatment Program: within three business days of request for services.
- Non-urgent follow-up Appointment with a non-physician: within ten business days of the request for services. *Behavioral Health Information Notice (BHIN) 24-020 and 23-041, 2024/2023 Network Certification Requirements for County Mental Health Plans (MHPs) and DMC-ODS Plans)*

Pursuant to Welfare and Institutions (W&I) Code section 14197(d)(3), the Plan shall ensure that all members seeking Narcotic Treatment Program (NTP) services are provided with an appointment within three business days of a service request. *(DMC-ODS Contract, Ex. A, Att. I, Article II (C)(6)(i)(b))*

Pursuant to W&I Code section 14197(d)(1)(A), the Plan shall ensure that all members seeking outpatient and intensive outpatient (non-NTP) services be provided with an appointment within ten business days of a service request. *(DMC-ODS Contract, Ex. A, Att. I, Article II (C)(6)(i)(a))*

Notwithstanding any relationships that the Plan may have with any subcontractor, the Plan is required to maintain ultimate responsibility for adhering to, and otherwise fully complying with, all terms and conditions of the Contract. *(DMC-ODS Contract, Ex. A, Att. I, Article II (E)(9)(ii))*

Plan's policy *0704.520, Network Adequacy Monitoring (revised 8/16/2*1) stated the Plan monitors contracted providers. The Plan runs monthly reports to monitor compliance and meets with contracted providers regularly to review the data and correct areas of non-compliance.

The Plan subcontracts with PHC for the provision of SUD services. PHC's policy, *MPNET101 Wellness and Recovery Access Standards and Monitoring* (revised 08/09/2023), stated that PHC has an established policy to abide by state and federal standards for the numbers and types of clinicians and facilities, as well as for the geographic distribution, appointment accessibility, and office and telephone availability. PHC monitors provider availability and accessibility on an annual basis. The policy stated that outpatient services are to be offered within ten business days from request to appointment and opioid treatment services are to be offered within three business days from the date of request.

Finding: The Plan did not ensure adult members who requested DMC-ODS services were offered non-urgent appointments within timely access to care standards.

Review of PHC's timely access documentation (specific to the Plan) revealed the following:

- One hundred and thirty-one adult Plan members noted on PHC's Timely Access Data Tool did not receive appointments for requested outpatient services within ten business days.
- One hundred and twenty-one adult Plan members noted on PHC's Timely Access Data Tool did not receive requested opioid treatment services within three business days.
- According to PHC's subcontractor Carelon's Access Line Log, seven adult Plan members who requested residential treatment services did not receive appointments within ten business days.

Although policy *0704.520* states the Plan runs monthly reports to monitor subcontractor compliance, review of submitted documentation indicated that the Plan lacked a process to directly monitor PHC, to ensure members were offered appointments timely. In an interview the Plan confirmed that it did not directly

monitor PHC's compliance with timeliness standards. As a result, the Plan relied solely on its subcontractor and did not generate internal reports from its EHR. In a written statement, the Plan further indicated that it was due to staff shortages and migration to a new Electronic Health Record system that timeliness reports were not generated to directly monitor subcontractor compliance.

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

It is important to note that specific to the DMC-ODS Regional Model, DHCS determines compliance not by individual county, but by the Regional Model as a whole. As a result, DHCS was not able to identify specific concerns with Humboldt's ability to meet timely access standards prior to the focused audit. For Fiscal Year 2023-24's annual network certification cycle, the DMC-ODS Regional Model was found to be non-compliant with all network adequacy standards for both youths and adults, including timely access standards. PHC continues to work with DHCS on their CAP.

Recommendation: Implement policies and procedures to ensure members receive timely appointments for DMC-ODS services and adequately monitor the Plan's contracted providers to ensure they meet timeliness standards.

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

The Plan shall ensure members receive timely and adequate Notice of Adverse Benefit Determination (NOABD), in writing and consistent within Article II (G)(2) of the DMC-ODS Contract. (*DMC-ODS Contract, Exhibit A, Attachment I, Article II (G)(2))*

Adverse benefit determination can mean the failure to provide services in a timely manner, as defined by the State. *(Code of Federal Regulations, 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. *(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 for non-urgent residential and outpatient services, or three business days from the initial request for narcotic treatment program 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 NOABDs were issued to members who did not receive services on time.

A review of the Plan's appointment tracking and monitoring system and NOABD log indicated the Plan did not any of the required NOABD related to timely access delays during the audit period when members were offered outpatient and opioid treatment appointments beyond timely access standards.

Although, policy 0704.500, stated the Plan will send members a NOABD in a timely manner, the Plan did not send NOABDs when timely access standards were not met. The Plan confirmed in writing not issuing NOABDs for timely access during the audit period. In an interview, the Plan stated that the NOABD process "fell off the radar" and lacked built-in monitoring. The Plan acknowledged the need for improved training and monitoring to address the issues.

When the Plan does not issue NOABDs for timely access to services, 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 to care standards. Ensure all network providers are informed of and trained on the updated NOABD policies and procedures.