DHCS REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF: TRINITY

2023

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
BEHAVIORAL HEALTH COMPLIANCE BRANCH

REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF

Trinity County Behavioral Health Services
Mental Health Services

2023

Contract Number:	17-94623
Audit Period:	July 1, 2022 Through June 30, 2023
Dates of Audit:	July 25, 2023 Through August 4, 2023
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I. INTRODUCTION

Trinity County Behavioral Health Services (Plan) provides a variety of Specialty Mental Health services (SMHS) for county citizens. The Plan is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of supporting the mental health needs of the community.

Trinity County is extremely rural and is the fourth smallest county in the State of California. The County has a population total of approximately 16,112 with 5,233 individuals eligible to receive Medi-Cal services. In the 2021 calendar year, the Plan serviced 329 beneficiaries and had a total of 16 active providers, 14 of which were county owned and operated and two contracted.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS audit of the Plan's Medi-Cal SMHS programs for the period of July 1, 2022 through June 30, 2023. The audit was conducted from July 25, 2023 through August 4, 2023. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference was held on December 15, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. On January 18, 2024, the Plan submitted a response to address the audit findings. The results of the DHCS evaluation 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 Protections, and Administrative and Program Integrity.

The prior DHCS triennial compliance review (covering fiscal years 2017 through 2020), identified deficiencies incorporated in the Corrective Action Plan (CAP). This year's audit included review of documents to determine 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 findings by category follows:

Category 1 – Network Adequacy and Availability of Services

The Plan is required to determine if Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) services were needed for children and youth that met beneficiary access criteria for SMHS. The Plan did not ensure to determine the need for ICC and IHBS services in children and youth who met SMHS criteria.

The Plan has an affirmative responsibility to determine the need of Therapeutic Foster Care (TFC) services to all children and youth who meet beneficiary access and medical necessity criteria for SMHS. The Plan did not ensure to assess the need for TFC services to children and youth who met beneficiary access and medical necessity criteria for SMHS.

The Plan is required to provide TFC services to all children and youth who meet beneficiary access and medical necessity criteria for SMHS. The Plan did not ensure provision of TFC services to children and youth who met beneficiary access and medical necessity criteria for SMHS.

The Plan is required to reassess the strengths and needs of children, youth, and their families at least once every 90 days, and as needed. The Plan did not ensure ICC and Child and Family Team (CFT) strengths and needs reassessments were conducted every 90 days.

Category 2 – Care Coordination and Continuity of Care

The Plan is required to coordinate services furnished to beneficiaries with services the beneficiary receives from any other managed care organization (MCO). The Plan did not ensure to coordinate services furnished to beneficiaries with services the beneficiary received from any other MCO.

Category 3 – Quality Assurance and Performance Improvement

Category 3 was not evaluated as part of this year's audit.

Category 4 – Access and Information Requirements

The Plan is required to provide a statewide, toll-free telephone number 24 hours a day, seven days per week, that provides information to beneficiaries about how to access SMHS. The Plan did not ensure its 24/7 access line system provided information on how to access SMHS and information on services needed to treat a beneficiary's urgent condition.

The Plan is required to maintain a written log of the initial requests for SMHS from beneficiaries. The log shall contain the name of the beneficiary, the date of the request, and the initial disposition of the request. The Plan did not log nor include all required log data for beneficiary calls requesting information on SMHS access.

Category 5 – Coverage and Authorization of Services

No findings were noted for the audit period.

Category 6 – Beneficiary Rights and Protections

The Plan is required to maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one business day of the date of receipt. The Plan did not maintain processes to collect and accurately track grievances to meet timeframes for written log entries and acknowledgment letters.

Category 7 – Program Integrity

The Plan is required to implement and maintain arrangements or procedures that include provision for the Plan's suspension of payments to a network provider for which there is a credible allegation of fraud. The Plan did not maintain procedures to ensure suspension of payments to network providers when there is a credible allegation of fraud.

The Plan is required to implement and maintain written policies for all employees containing detailed information regarding the False Claims Act and other federal and state laws and employee whistleblower protection. The Plan did not maintain policies that detailed information regarding the False Claims Act and employees' rights to be protected as whistleblowers.

The Plan is required to maintain policies for the treatment of recoveries of all overpayments due to fraud, waste, and abuse (FWA). The Plan did not maintain a process for identifying and recovering overpayments due to FWA.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted this audit of the Plan to ascertain that SMHS provided to beneficiaries comply with federal and state laws, Medi-Cal regulations and guidelines, and the county's health system Contract.

PROCEDURE

The audit was conducted from July 25, 2023 through August 4, 2023, for the audit period of July 1, 2022 through June 30, 2023. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine the effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan representatives.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

ICC/IHBS/TFC Determination: 40 children and youth assessments were reviewed for criteria and service determination.

ICC/IHBS Provision of Services: Ten children and youth medical records were reviewed for the provision of ICC and/or IHBS services.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Ten beneficiary files were reviewed for evidence of handoff following hospitalization discharge back to the Plan.

Category 4 – Access and Information Requirements

Access Line Test Calls: Five test calls requesting information about SMHS and how to treat an urgent condition were made to the Plan's statewide 24/7 toll-free number to confirm compliance with regulatory requirements; two test calls requesting information about the beneficiary 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 Test Call Log: Five test calls were made to review if the Plan logs the test calls and to confirm if the Plan's log contains all required components.

Category 5 – Coverage and Authorization of Services

Notice of Adverse Benefit Determination: 21 beneficiary files were reviewed for evidence of appropriate documentation and completeness.

Authorizations: Ten beneficiary files were reviewed for evidence of appropriate treatment authorization process including the concurrent review process.

Category 6 – Beneficiary Rights and Protections

Grievance Procedures: The sample consisted of one exempt grievance. No additional grievances or appeals were received during the audit period.

Category 7 – Program Integrity

FWA Reporting: There were no reportable cases of FWA during the audit period.

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CATEGORY 1 – NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

1.2	Children's Services

1.2.1 Assessment of ICC and IHBS Services

The Plan is required to update policies and procedures as needed to ensure compliance with Behavioral Health Information Notice (BHIN) policies. The Plan is required to update beneficiary handbooks, manuals, and related materials to ensure criteria for SMHS for individuals under 21 years of age and for adults is accurately reflected in all materials as noted within BHIN 21-073. *(Contract, Exhibit A, Attachment 2 (1))*

The Plan is required to provide services for children and youth that meet beneficiary access criteria for SMHS. The Plan has an affirmative responsibility to determine if ICC and IHBS are needed. *(BHIN 21-073)*

Plan policy *3312 Consumer Care – ICC, IHBS and TFC Services* (*revised June 2023*), states that the Plan will provide and arrange ICC and IHBS services to all children and youth under the age of 21 years old who meet medically necessity criteria for those services.

Finding: The Plan did not ensure to determine the need for ICC and IHBS services in children and youth who met SMHS criteria.

The verification study included the review of 40 children's medical records, of which 14 children who received an initial assessment were found to have indicators for consideration for ICC and/or IHBS. However, there was no evidence that a determination for needed services was made.

The Plan did not maintain an adequate process to ensure all children that met beneficiary access criteria for SMHS were assessed for ICC or IHBS determination. The Plan policy *3312* did not clearly address the assessment requirement to determine if ICC or IHBS services were needed. Although the Plan stated in an interview that staff utilize clinical team meetings to determine if ICC and IHBS services would be appropriate, the Plan could not verify whether these services were actually considered for every child.

When the Plan does not determine the need for ICC and IHBS services, this may impact the Plan's ability to adequately meet the mental health needs of children and youth beneficiaries.

Recommendation: Revise policies and implement procedures to ensure children and youth who meet beneficiary access criteria for SMHS are assessed to determine if ICC and IHBS services are needed.

1.2.2 Assessment of Need for TFC Services

The Plan is required to update policies and procedures as needed to ensure compliance with BHIN policies. The Plan is required to update beneficiary handbooks, manuals, and related materials to ensure criteria for SMHS for individuals under 21 years of age and for adults is accurately reflected in all materials as noted within BHIN 21-073. *(Contract, Exhibit A, Attachment 2(1))*

The Plan has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need TFC. *(BHIN 21-073; Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd ed., Jan. 2018, pp. 11 & 34.)*

Plan policy *3312 Consumer Care – ICC, IHBS and TFC Services* (*revised June 2023*), states that the Plan will provide and arrange ICC, IHBS, and TFC services to all children and youth under the age of 21 years old who meet medically necessity criteria for those services.

Finding: The Plan did not ensure to assess the need for TFC services to children and youth who met beneficiary access and medical necessity criteria for SMHS.

The Plan did not maintain a system to ensure children were assessed for the need of TFC services. The Plan's policy *3312* did not clearly address the assessment requirement to determine if TFC services were needed. In addition, the Plan confirmed in an interview that determinations for TFC were not conducted due to a limited number of foster children within the County.

Failure to make determinations for children who might be considered for TFC services may impact the Plan's ability to adequately meet the mental health needs of youth beneficiaries.

This is a repeat finding of the prior review (Fiscal Year 2019/2020) – A.III.G – Assessment of Need for TFC Services

Recommendation: Revise policies and implement procedures to ensure children and youth who meet beneficiary access criteria for SMHS are assessed to determine if TFC services are needed.

1.2.3 Provision of TFC Services

The Plan is required to provide or arrange, and pay for, the following medically necessary covered SMHS to beneficiaries. *(Contract, Exhibit A, Attachment 2)*

The Plan has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need TFC. The Plan must provide TFC services to all children and youth who meet beneficiary access and medical necessity criteria for SMHS. (*BHIN 21-073; Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd ed., Jan. 2018, pp. 11 & 34.)*

The Plan is required to maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract for all beneficiaries. *(Contract, Exhibit A, Attachment 8(3)(B))*

Plan policy *3312 Consumer Care – ICC, IHBS and TFC Services* (*revised June 2023*), states that the Plan will provide TFC services to all children and youth under the age of 21 years old who meet medically necessity criteria for those services and will collaborate with other agencies to provide coordinated care to beneficiaries.

Finding: The Plan did not ensure the provision of TFC services by contracting with TFC providers.

The Plan did not furnish requested evidence of subcontracts with TFC providers.

The Plan confirmed in an interview that TFC services were not provided due to the lack of a TFC providers within the County. The Plan also stated that due to a limited number of foster children within the County, the Plan did not perceive a need to contract with outside agencies for coordinated care.

When the Plan does not contract with TFC providers, it cannot ensure the provision of medically necessary TFC services for children and youth in need of such services.

Recommendation: Revise and implement policies and procedures to ensure the provision of TFC services by contracting with TFC providers.

1.2.4 ICC Strengths and Needs Reassessments

The Plan is required to comply with all state and federal statutes and regulations, the terms of the DHCS Agreement, BHINs, and any other applicable authorities. *(Contract, Exhibit E (6)(H))*

The Plan's ICC Coordinator and CFT are required to reassess the strengths and needs of children, youth, and their families at least once every 90 days, and as needed. *(Medi-Cal Manual for ICC, IHBS, and TFC services for Medi-Cal Beneficiaries, (3rd edition, January 2018))*

Finding: The Plan did not ensure ICC and CFT strengths and needs reassessments were conducted every 90 days.

Plan policy *3312 Consumer Care – ICC, IHBS and TFC Services* (*revised June 2023*), states that the Plan will collaborate with other agencies to provide coordinated care to beneficiaries and will ensure a CFT meeting is held; however, there is no statement if this meeting is held every 90 days, and as needed. Additionally, this policy does not state if the Plan's ICC coordinator and CFT conducts a reassessment of strengths and needs every 90 days for beneficiaries receiving ICC services.

The Plan stated in an interview that its staff participated in CFT meetings for children who received ICC services. These meetings were coordinated by an outside agency but there was minimal coordination to ensure compliance with the required timeframe for ICC reassessments. The Plan could not confirm if these CFT meetings were held every 90 days, and as needed.

Failure to conduct reassessment meetings every 90 days may impact the Plan's ability to address children and youths' changing needs in a timely manner such as safety concerns, risk of placement disruption, or ineffective support services.

Recommendation: Revise policies and implement procedures to ensure the strengths and needs of children receiving ICC services are assessed every 90 days, and as needed.

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CATEGORY 2 – CARE COORDINATION AND CONTINUNITY OF CARE

2.1	Coordination of Care Requirements

2.1.1 Referrals and Coordination of Care

The Plan is required to coordinate services furnished to beneficiaries with services the beneficiary receives from any other MCO, in Fee-for-service Medi-Cal, from community and social support providers, and other human services agencies used by its beneficiaries. *(Contract, Exhibit A, Attachment 10(1)(A)(2))*

The Plan shall be responsible for providing or arranging and paying for SMHS for Medi-Cal eligible individuals in its county who require an assessment or meet criteria for access to SMHS. California Code of Regulations (CCR), Title 9, section 1810.228) The Contractor shall accept these individuals in the order in which they are referred (including self-referral) without restriction (unless authorized by Centers for Medicare and Medicaid Services), up to the limits set under this Contract. Code of Federal Regulations (CFR) Title 42, section 438.3(d)(1); *Contract, Exhibit A, Attachment 7(1)(B))*

The *Memorandum of Understanding (MOU), Coordination & Continuity of Care (executed 2019)* detailed the expectations and delegated activities between the Plan and the MCO. The MOU addresses shared responsibilities, requirements for program oversight, assessment and referral procedures, and protocols for the beneficiary's transition, coordination, and continuity of care. The MOU states that the Plan will accept and track MCO referrals. The Plan and the MCO will meet at least semi-annually to review the quality of the program and summarize their findings in reports that include the tracking of cross system referrals.

Finding: The Plan did not ensure to coordinate services furnished to beneficiaries with services the beneficiary receives from any other MCO.

The Plan lacked written policies and procedures regarding intake, processing, and monitoring of referrals received from the MCO.

Although the MOU addressed requirements for program oversight and referral procedures, the Plan did not implement its responsibility to coordinate care for referrals received from the MCO. The Plan did not maintain a log of referrals from the MCO. There was no evidence that the Plan conducted meetings with the MCO to conduct

oversight and review the effectiveness of the MOU, that includes ensuring referrals are processed for medically necessary services.

In an interview, the Plan explained that small staff size and staffing shortages contributed to difficulties in fully implementing the MOU. The Plan explained that its attempts to arrange for joint meetings with the MCO was unsuccessful and that there were no joint meetings held during the audit period. The Plan also expressed a lack of understanding regarding the referral of beneficiaries to the MCO for lower levels of care and ongoing services when medical necessity criteria for SMHS were no longer met.

When the Plan does not fully implement its MOU by not processing and tracking MCO referrals, this can lead to poor coordination of care that may result in poor health outcomes if the provision of behavioral health services is missed or delayed.

Recommendation: Develop and implement policies and procedures to ensure the Plan coordinates services furnished to beneficiaries with services the beneficiary receives from any other MCO.

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CATEGORY 4 – ACCESS AND INFORMATION REQUIREMENTS

4.2	Access Line and Written Log

4.2.1 SMHS Access Information

The Plan shall provide a statewide, toll-free telephone number 24 hours a day, seven days per week that provides language capabilities in all languages spoken by beneficiaries of the county. The toll-free line shall provide information to beneficiaries about how to access SMHS services. The toll-free line shall also provide information regarding how to assess whether medical necessity criteria are met, services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes*. (CCR, Title 9, Chapter 11, sections 1810.405(d) and 1810.410(e)(1))*

Plan policy *2309, 24/7 Access Line Toll Free Number & Tracking Contract (revised September 18, 2012and September 9, 2023),* describes the Plan's provision of a statewide, toll-free telephone number that is available 24 hours a day and seven days per week. The policy notes the requirements to provide beneficiaries with SMHS access information required to assess medical necessity, urgent and crisis care services and the requirement for the inquiry call to be contained within a written log.

Finding: The Plan did not ensure its 24/7 access line system provided information on how to access SMHS and information on services needed to treat a beneficiary's urgent condition.

DHCS conducted seven test calls to the Plan's statewide 24/7 toll-free number. Of the seven test calls made, three calls did not provide information about how to access SMHS, and two calls did not provide information needed to treat a beneficiary's urgent condition.

Although the Plan's policy *2309* required that its 24/7 access line system inform beneficiaries with the obligatory SMHS access information, the Plan did not have an adequate monitoring system to ensure beneficiaries received the necessary SMHS access information. The Plan maintained its 24/7 access line internally during normal business hours and utilized a contracted provider for after-hour services. The Plan conducted internal test calls monthly and utilized the result data for staff training; however, the Plan did not have a process to monitor its after-hours contracted provider.

In an interview, the Plan acknowledged it did not have a process to monitor its after-hours contracted provider to ensure that required access information was provided to beneficiaries calling the 24/7 access line.

When the Plan does not monitor to ensure the provision of information for access to care, beneficiaries may not receive necessary details to make informed decisions. This can result in poor mental health outcomes due to missed or delayed access to necessary behavioral health services.

This is a repeat finding of the prior review (Fiscal Year 2019/2020) – D.VI.B1-4 – 24/7 Access Line Information

Recommendation: Revise and implement policies and procedures to ensure the Plan's 24/7 access line system provides information on how to access SMHS and information on services needed to treat a beneficiary's urgent condition.

4.2.2 Access Call Log

Beneficiary calls requesting information about SMHS access and services needed to treat a beneficiary's urgent condition are required to be logged. *(CCR, Title 9, section 1810, subdivision 405(f))*

The Plan is required to maintain a written log of the initial requests for SMHS from beneficiaries as follows: Requests shall be recorded whether they are made via telephone, in writing, or in person; The log shall contain the name of the beneficiary, the date of the request, and the initial disposition of the request. *(CCR, Title 9, section 1810.405, subdivision (f))*

Plan policy *2309, 24.7 Access Line Toll Free Number & Tracking Contract (revised September 18, 2012 and September 9, 2023*) describes the Plan's provision of a statewide, toll-free telephone number that is available 24 hours a day and seven days per week. The policy notes the requirements to provide beneficiaries with SMHS access information required to assess medical necessity, urgent and crisis care services and the requirement for the inquiry call to be contained within a written log.

Finding: The Plan did not log nor include all required log data for beneficiary calls requesting information on SMHS access.

In a verification study, seven test calls were made to the Plan's 24/7 access line. Calls were made requesting information on SMHS access. Subsequent to the calls made, a review of the log showed that five of seven required test calls were not recorded in the Plan's written log for initial SMHS requests. The verification study also revealed that the written log did not include all required log data such as the beneficiary's name, request date, and the initial disposition of the request.

Although the Plan's Policy *2309* addresses the contractual requirement to maintain a written inquiry log, it did not delineate all the required log data. In an interview, the Plan stated that it lacked oversight and monitoring to ensure adherence to written log requirements for initial SMHS requests.

An inaccurate log of initial information requests for SMHS can result in the Plan's inability to effectively monitor and track the request in order to provide timely access to behavioral health services.

This is a repeat finding of the prior review (Fiscal Year 2019/2020) – D.VI.C2. – SMHS Information Inquiry Log

Recommendation: Implement policies and procedures to ensure to log and include all required log data for beneficiary calls requesting information on SMHS access.

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CATEGORY 6 – BENEFICIARY RIGHTS AND PROTECTION

6.1	Grievance and Appeal System Requirements

6.1.1 Written Grievance Submission

The Plan shall have a grievance and appeal system that shall be implemented to handle appeals of adverse benefit determinations and grievances and shall include processes to collect and track information. *(Contract, Exhibit A, Attachment 12(1)(A))*

The Plan is required to maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one business day of the date of receipt of the grievance, appeal, or expedited appeal. *(Contract, Exhibit A, Attachment 12(2)(A))*

The Plan is required to provide the beneficiary written acknowledgement of receipt of submitted grievances. The written acknowledgement to the beneficiary must be postmarked within five calendar days of receipt of the grievance. *(Contract, Exhibit A, Attachment 12(3)(B))*

Plan policy *1104, Beneficiary Problem Resolution Process (July1,2001, revised October25,2022),* describes the Plan's beneficiary problem resolution process that includes timeframes for grievance log entries and grievance acknowledgment letters. The Plan maintains a grievance and appeal log to record grievances, appeals, and expedited appeals in the log within one business day of the date of receipt of the grievance, appeal, or expedited appeal. Additionally, the Plan will send the beneficiary a written acknowledgement of receipt of submitted grievances that must be postmarked within five calendar days of receipt of the grievance.

Finding: The Plan did not maintain processes to collect and accurately track grievances to meet timeframes for written log entries and acknowledgment letters.

The timeframe for logging grievance entries and sending out of grievance acknowledgement letters is based on the grievance receipt date. In view of this premise, the Plan did not ensure timely grievance log entries and grievance acknowledgement letters due to inaccurate recording of the grievance receipt date and incomplete entries in the tracking log. Review of the Plan's grievance monitoring and tracking log revealed incomplete entries that lacked the date when grievances were received.

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Grievances from a submission box were retrieved once a week resulting in non-implementation of the Plan's policy to log grievances within one business day of the grievance receipt date.

In an interview, the Plan explained that because of the low number of grievances submitted by beneficiaries, the Plan checks and logs retrieved grievances from the submission box approximately once a week. In addition, the Plan acknowledged that it incorrectly interpreted the grievance receipt date as the collection date and not the date when the grievance was received by or submitted to the Plan.

When the Plan does not accurately track grievances, this can cause a delay in the grievance process which can lead to delays in beneficiary access to necessary services.

Recommendation: Implement policies and procedures to collect and accurately track grievances to meet timeframes for written log entries and acknowledgment letters.

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CATEGORY 7 – PROGRAM INTEGRITY

7.2	Fraud Reporting Requirements

7.2.1 Provider Payment Suspension

The Plan is required to implement and maintain arrangements or procedures that include provision for the Plan's suspension of payments to a network provider for which there is a credible allegation of fraud. *(Contract, Exhibit A, Attachment 13, 4(D))*

The Plan is required to implement and maintain arrangements or procedures designed to detect and prevent FWA that include prompt reporting to DHCS. *(CFR, Title 42, section 438.608(a)(7))*

Plan policy *1004, Compliance Officer (August 16,2016)*, ensures written policies, procedures and standards for all employees and subcontractor or agent, that articulate the Plan's commitment to comply with all applicable federal and state laws, regulations, and standards. The policy addresses the development, operation, and oversight of the Compliance Program. The policy also ensures regular reporting to the Compliance Program Committee.

Finding: The Plan did not maintain procedures to ensure suspension of payments to network providers when there is a credible allegation of fraud.

Although the Plan's policy *1004* addresses the commitment to comply with all applicable laws and regulations specific to program integrity and FWA, the policy did not delineate the process to identify providers with a credible allegation of fraud and how the Plan suspends payments to these providers.

In an interview, the Plan confirmed it had no policies and procedures on how the Plan will suspend providers with credible allegations of fraud.

When there are no processes to identify and suspend payments to network providers for which there are credible allegations of fraud, this could lead to financial losses to the Medi-Cal program that may impact the quality of health care.

Recommendation: Develop policies outlining steps to suspend payments to network providers when there are credible allegations of fraud.

7.2.2 Whistleblower Protection Policy

The Plan is required to implement and maintain written policies for all employees and any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws, including information about rights of employees to be protected as whistleblowers. *(Contract, Exhibit A, Attachment 13, 4(C))*

Finding: The Plan did not maintain policies that detailed information regarding the False Claims Act and employees' rights to be protected as whistleblowers.

In an interview, the Plan acknowledged it does not maintain policies that outline the requirement regarding employee rights to protection as whistleblowers. The Plan provided multiple policies throughout its system of care specific to program integrity and FWA; however, the polices did not delineate the False Claims Act and protection of whistleblowers.

Failure to implement policies about the False Claims Act and employee whistleblower protection may result in FWA going unreported or limit employee whistleblowing due to fear of retaliation.

Recommendation: Develop and implement policy that outlines information regarding the False Claims Act including information about rights of employees to be protected as whistleblowers.

7.2.3 Recovery of FWA Overpayment

The Plan is required to report to the Department within 60 calendar days when it has identified payments in excess of amounts specified for reimbursement of Medicaid services. The Plan is required to maintain policies for the treatment of recoveries of all overpayments due to FWA. The policy is required to specify the process, timeframes, and documentation required for reporting the recovery of all overpayments. *(Contract, Exhibit A, Attachment 3(7))*

The Plan is required to implement and maintain arrangements or procedures designed to detect and prevent FWA that include prompt reporting to DHCS. *(CFR, Title 42, section 438.608(a)(7))*

Plan policy *1004, Compliance Officer (August 16, 2016)*, ensures written policies, procedures, and standards for all employees and subcontractor or agent that articulate the Plan's commitment to comply with all applicable federal and state laws, regulations, and standards. The policy addresses the development, operation, and oversight of the Compliance Program. The policy also ensures regular reporting to the Compliance Program Committee.

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Plan policy *1008 Anti-Fraudulent Billing and Reporting Compliance (revised October 5,* 2022*)* ensures written policies, procedures, and standards for all employees and subcontractor or agent, that articulate the Plan's commitment to comply with all applicable federal and state laws, regulations, and standards. The policy also ensures all suspected fraud is reported to DHCS.

Finding: The Plan did not maintain a process for identifying and recovering overpayments due to FWA.

Although, the Plan's policy *1008* ensures the reporting of suspected fraud, it did not delineate the requirement to identify and recover overpayments due to FWA. In addition, the Plan acknowledged in an interview that it does not have policies or procedures outlining this requirement.

Failure to implement a system designed to identifying and recover overpayments due to FWA may result in misuse of state funding towards fraudulent services.

Recommendation: Develop policies and implement procedures to identify and recover overpayments due to FWA.